```
                                        POSITIONS
            NAME              TYPE  LENGTH BEG  END                           CONTENTS
----------------------------  ----  ------ ---------  ------------------------------------------------------------

****  Carrier Claim Record    REC    VAR              Carrier claim record (other than DMERC) for version I
                                                      of the NCH.

                                                      STANDARD ALIAS: CARR_CLM_REC
                                                      SYSTEM ALIAS: UTLCARRI

****  DESY Header Group        GROUP   50     1    50  DESY header for whole record output.

   1. DESY System User         CHAR    30     1    30  A user-defined field that holds the description
                                                       of the request. For example, "Cross-referenced
                                                       HICs".

                                                       STANDARD ALIAS: DSY_SYSTEM_USER

   2. Filler                   CHAR    11    31    41  Filler

                                                       STANDARD ALIAS: DSY_TBD

   3. DESY Sort Key            CHAR     9    42    50  This field contains the key to tie claims
                                                       together for one beneficiary regardless of HICAN.

                                                       STANDARD ALIAS: DSY_SORT_KEY

****  Carrier Claim Fixed Group GROUP 375    51   425  Fixed portion of the carrier claim record for
                                                       version I of the NCH.

                                                       STANDARD ALIAS: CARR_CLM_FIX_GRP

****  Claim Record Identification GROUP  8    51    58  Effective with Version 'I' the record
      Group                                            length, version code, record identification,
                                                       code and NCH derived claim type code were moved
                                                       to this group for internal NCH processing.

                                                       STANDARD ALIAS: CLM_REC_IDENT_GRP

   4. Record Length Count      PACK     3    51    53  Effective with Version H, the count (in bytes)
                                                       of the length of the claim record.

                                                       NOTE:  During the Version H conversion this field
                                                              was populated with data throughout history
                                                              (back to service year 1991).
```

5 DIGITS SIGNED

DB2 ALIAS: REC_LNGTH_CNT
SAS ALIAS: REC_LEN
STANDARD ALIAS: REC_LNGTH_CNT

SOURCE:
NCH

```
5. NCH Near-Line Record      CHAR    1    54   54   The code indicating the record version of the Nearline file
   Version Code                                     where the institutional, carrier or DMERC claims data are
                                                    stored.
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                         POSITIONS
              NAME              TYPE  LENGTH BEG  END                              CONTENTS
------------------------------  ----  ------ ---------  ------------------------------------------------------------
```

DB2 ALIAS: NCH_REC_VRSN_CD
SAS ALIAS: REC_LVL
STANDARD ALIAS: NCH_NEAR_LINE_REC_VRSN_CD
TITLE ALIAS: NCH_VERSION

CODES:
A = Record format as of January 1991
B = Record format as of April 1991
C = Record format as of May 1991
D = Record format as of January 1992
E = Record format as of March 1992
F = Record format as of May 1992
G = Record format as of October 1993
H = Record format as of September 1998
I = Record format as of July 2000

COMMENT:
Prior to Version H this field was named:
CLM_NEAR_LINE_REC_VRSN_CD.

SOURCE:
NCH

```
6. NCH Near Line Record       CHAR    1    55   55   A code defining the type of claim record being processed.
   Identification Code
```

COMMON ALIAS: RIC
DB2 ALIAS: NEAR_LINE_RIC_CD
SAS ALIAS: RIC_CD
STANDARD ALIAS: NCH_NEAR_LINE_RIC_CD

```
                                            carrier.txt
                              TITLE ALIAS: RIC

                              CODES:
                                REFER TO: NCH_NEAR_LINE_RIC_TB
                                           IN THE CODES APPENDIX

                              COMMENT:
                              Prior to Version H this field was named:
                              RIC_CD.

                              SOURCE:
                              NCH

   7. NCH MQA RIC Code          CHAR    1   56   56  Effective with Version H, the code used (for internal
                                                     editing purposes) to identify the record being processed
                                                     through HCFA's CWFMQA system.

                                                     NOTE:  Beginning with NCH weekly process date 10/3/97 this
                                                            field was populated with data. Claims processed prior
                                                            to 10/3/97 will contain spaces in this field.

                                                     DB2 ALIAS: NCH_MQA_RIC_CD
                                                     SAS ALIAS: MQA_RIC
                                                     STANDARD ALIAS: NCH_MQA_RIC_CD
                                                     TITLE ALIAS: MQA_RIC
1                         Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                       POSITIONS
           NAME                 TYPE  LENGTH BEG  END                          CONTENTS
   ---------------------------- ---- ------ --------- -----------------------------------------------------------

                              CODES:
                              1 = Inpatient
                              2 = SNF
                              3 = Hospice
                              4 = Outpatient
                              5 = Home Health Agency
                              6 = Physician/Supplier
                              7 = Durable Medical Equipment

                              SOURCE:
                              NCH QA PROCESS

   8. NCH Claim Type Code       CHAR    2   57   58  The code used to identify the type of claim record being
                                                     processed in NCH.

                                                     NOTE1:  During the Version H conversion this field was
                                                             populated with data through- out history (back to
                                            Page 3
```

```
                                    carrier.txt
                                      service year 1991).

                          NOTE2:  During the Version I conversion this field was
                                  expanded to include inpatient 'full' encounter
                                  claims (for service dates after 6/30/97).
                                  Placeholders for Physician and Outpatient encounters
                                  (available in NMUD) have also been added.

                          DB2 ALIAS: NCH_CLM_TYPE_CD
                          SAS ALIAS: CLM_TYPE
                          STANDARD ALIAS: NCH_CLM_TYPE_CD
                          SYSTEM ALIAS: LTTYPE
                          TITLE ALIAS: CLAIM_TYPE

                          DERIVATION:
                          FFS CLAIM TYPE CODES DERIVED FROM:
                            NCH CLM_NEAR_LINE_RIC_CD
                            NCH PMT_EDIT_RIC_CD
                            NCH CLM_TRANS_CD
                            NCH PRVDR_NUM

                          INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                            (Pre-HDC processing -- AVAILABLE IN NCH)
                            CLM_MCO_PD_SW
                            CLM_RLT_COND_CD
                            MCO_CNTRCT_NUM
                            MCO_OPTN_CD
                            MCO_PRD_EFCTV_DT
                            MCO_PRD_TRMNTN_DT

                          INPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
                            (HDC processing -- AVAILABLE IN NMUD)
                            FI_NUM
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                       POSITIONS
            NAME                 TYPE  LENGTH BEG  END                         CONTENTS
---------------------------- ---- ------ --------- ------------------------------------------------------------
                                                     INPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE DERIVED
                                                     FROM: (HDC processing -- AVAILABLE IN NMUD)
                                                       FI_NUM
                                                       CLM_FAC_TYPE_CD
                                                       CLM_SRVC_CLSFCTN_TYPE_CD
                                                       CLM_FREQ_CD
                                                     NOTE:  From 7/1/97 to the start of HDC processing(?),
                                                     abbreviated inpatient encounter claims are not
```

carrier.txt
available in NCH or NMUD.

PHYSICIAN 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  CARR_NUM
  CLM_DEMO_ID_NUM

OUTPATIENT 'FULL' ENCOUNTER TYPE CODE DERIVED FROM:
  (AVAILABLE IN NMUD)
  FI_NUM

OUTPATIENT 'ABBREVIATED' ENCOUNTER TYPE CODE
DERIVED FROM: (AVAILABLE IN NMUD)
  FI_NUM
  CLM_FAC_TYPE_CD
  CLM_SRVC_CLSFCTN_TYPE_CD
  CLM_FREQ_CD

DERIVATION RULES:

  SET CLM_TYPE_CD TO 10 (HHA CLAIM) WHERE THE
  FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V','W' OR 'U'
  2.   PMT_EDIT_RIC_CD EQUAL 'F'
  3.   CLM_TRANS_CD EQUAL '5'

  SET CLM_TYPE_CD TO 20 (SNF NON-SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM IS NOT 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 30 (SNF SWING BED CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
  2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
  3.   CLM_TRANS_CD EQUAL '0' OR '4'
  4.   POSITION 3 OF PRVDR_NUM EQUAL 'U', 'W', 'Y'
       OR 'Z'

  SET CLM_TYPE_CD TO 40 (OUTPATIENT CLAIM)
  WHERE THE FOLLOWING CONDITIONS ARE MET:
  1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
  2.   PMT_EDIT_RIC_CD EQUAL 'D'
  3.   CLM_TRANS_CD EQUAL '6'

```
                                    POSITIONS
          NAME               TYPE  LENGTH BEG  END                              CONTENTS
-----------------------------  ----  ------ ---------  -------------------------------------------------------------
```

                                                      SET CLM_TYPE_CD TO 41 (OUTPATIENT 'FULL'
                                                      ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                                                      THE FOLLOWING CONDITIONS ARE MET:
                                                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'W'
                                                      2.   PMT_EDIT_RIC_CD EQUAL 'D'
                                                      3.   CLM_TRANS_CD EQUAL '6'
                                                      4.   FI_NUM = 80881

                                                      SET CLM_TYPE_CD TO 42 (OUTPATIENT 'ABBREVIATED'
                                                      ENCOUNTER CLAIMS -- AVAILABLE IN NMUD)
                                                      1.   FI_NUM = 80881
                                                      2.   CLM_FAC_TYPE_CD = '1' OR '8'; CLM_SRVC_
                                                           CLSFCTN_TYPE_CD = '2', '3' OR '4' &
                                                           CLM_FREQ_CD = 'Z', 'Y' OR 'X'

                                                      SET CLM_TYPE_CD TO 50 (HOSPICE CLAIM)
                                                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                      2.   PMT_EDIT_RIC_CD EQUAL 'I'
                                                      3.   CLM_TRANS_CD EQUAL 'H'

                                                      SET CLM_TYPE_CD TO 60 (INPATIENT CLAIM)
                                                      WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                      2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'
                                                      3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'

                                                      SET CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                                      CLAIM - PRIOR TO HDC PROCESSING - AFTER 6/30/97 -
                                                      12/4/00) WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                      1.   CLM_MCO_PD_SW = '1'
                                                      2.   CLM_RLT_COND_CD = '04'
                                                      3.   MCO_CNTRCT_NUM
                                                           MCO_OPTN_CD = 'C'
                                                           CLM_FROM_DT & CLM_THRU_DT ARE WITHIN THE
                                                           MCO_PRD_EFCTV_DT & MCO_PRD_TRMNTN_DT
                                                           ENROLLMENT PERIODS

                                                      SET_CLM_TYPE_CD TO 61 (INPATIENT 'FULL' ENCOUNTER
                                                      CLAIM -- EFFECTIVE WITH HDC PROCESSING) WHERE THE
                                                      FOLLOWING CONDITIONS ARE MET:
                                                      1.   CLM_NEAR_LINE_RIC_CD EQUAL 'V'
                                                      2.   PMT_EDIT_RIC_CD EQUAL 'C' OR 'E'

```
                                carrier.txt
                      3.   CLM_TRANS_CD EQUAL '1' '2' OR '3'
                      4.   FI_NUM = 80881

                      SET CLM_TYPE_CD TO 62 (INPATIENT 'ABBREVIATED'
                      ENCOUNTER CLAIM -- AVAILABLE IN NMUD) WHERE
                      THE FOLLOWING CONDITIONS ARE MET:
                      1.   FI_NUM = 80881 AND
                      2.   CLM_FAC_TYPE_CD = '1'; CLM_SRVC_CLSFCTN_
                           TYPE_CD = '1'; CLM_FREQ_CD = 'Z'
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                      POSITIONS
              NAME                TYPE  LENGTH BEG  END                        CONTENTS
    ----------------------------  ----  ------ ---------  --------------------------------------------------------------

                                                         SET CLM_TYPE_CD TO 71 (RIC O non-DMEPOS CLAIM)
                                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                                         2.   HCPCS_CD not on DMEPOS table

                                                         SET CLM_TYPE_CD TO 72 (RIC O DMEPOS CLAIM)
                                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'O'
                                                         2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                              more line item(s) match the HCPCS on the
                                                              DMEPOS table).

                                                         SET CLM_TYPE_CD TO 73 (PHYSICIAN ENCOUNTER CLAIM--
                                                         EFFECTIVE WITH HDC PROCESSING) WHERE THE FOLLOWING
                                                         CONDITIONS ARE MET:
                                                         1.   CARR_NUM = 80882 AND
                                                         2.   CLM_DEMO_ID_NUM = 38

                                                         SET CLM_TYPE_CD TO 81 (RIC M non-DMEPOS DMERC
                                                            CLAIM)
                                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                         2.   HCPCS_CD not on DMEPOS table

                                                         SET CLM_TYPE_CD TO 82 (RIC M DMEPOS DMERC CLAIM)
                                                         WHERE THE FOLLOWING CONDITIONS ARE MET:
                                                         1.   CLM_NEAR_LINE_RIC_CD EQUAL 'M'
                                                         2.   HCPCS_CD on DMEPOS table (NOTE: if one or
                                                              more line item(s) match the HCPCS on the
                                                              DMEPOS table).

                                             CODES:
```

```
                                    REFER TO: NCH_CLM_TYPE_TB
                                              IN THE CODES APPENDIX

                                    SOURCE:
                                    NCH

****  Carrier/DMERC Claim Link    GROUP   125    59  183  Effective with Version 'I', this group
      Group                                                was added to the carrier and DMERC records
                                                           to keep fields common across all record types
                                                           in the same position.  Due to OP PPS, several
                                                           fields on the Institutional record had to be
                                                           moved to a link group so those same fields had
                                                           to be moved on the carrier records eventhough
                                                           OP PPS only affects institutional claims.

                                                           STANDARD ALIAS: CARR_DMERC_CLM_LINK_GRP

****  Claim Locator Number Group  GROUP    11    59   69  This number uniquely identifies the beneficiary in
                                                           the NCH Nearline.

                                                           COMMON ALIAS: HIC
                                                           STANDARD ALIAS: CLM_LCTR_NUM_GRP
                                                           TITLE ALIAS: HICAN
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                      POSITIONS
         NAME                TYPE  LENGTH BEG   END                          CONTENTS
------------------------------  ----  ------ ---------  -----------------------------------------------------------

  9. Beneficiary Claim Account   CHAR     9    59   67  The number identifying the primary beneficiary
     Number                                             under the SSA or RRB programs submitted.

                                                        COMMON ALIAS: CAN
                                                        DA3 ALIAS: CLAIM_ACCOUNT_NUMBER
                                                        DB2 ALIAS: BENE_CLM_ACNT_NUM
                                                        SAS ALIAS: CAN
                                                        STANDARD ALIAS: BENE_CLM_ACNT_NUM
                                                        TITLE ALIAS: CAN

                                                        SOURCE:
                                                        SSA,RRB

                                                        LIMITATIONS:
                                                        RRB-issued numbers contain an overpunch in
                                                        the first position that may appear as a plus
                                                        zero or A-G.   RRB-formatted numbers may
                                                        cause matching problems on non-IBM machines.
```

```
 10. NCH Category Equatable      CHAR     2    68   69  The code categorizing groups of BICs
     Beneficiary Identification                          representing similar relationships between
     Code                                                the beneficiary and the primary wage earner.

                                                         The equatable BIC module electronically matches
                                                         two records that contain different BICs where
                                                         it is apparent that both are records for the
                                                         same beneficiary.  It validates the BIC and
                                                         returns a base BIC under which to house the
                                                         record in the National Claims History (NCH)
                                                         databases.  (All records for a beneficiary
                                                         are stored under a single BIC.)

                                                         COMMON ALIAS: NCH_BASE_CATEGORY_BIC
                                                         DB2 ALIAS: CTGRY_EQTBL_BIC
                                                         SAS ALIAS: EQ_BIC
                                                         STANDARD ALIAS: NCH_CTGRY_EQTBL_BIC_CD
                                                         TITLE ALIAS: EQUATED_BIC

                                                         CODES:
                                                           REFER TO: CTGRY_EQTBL_BENE_IDENT_TB
                                                                     IN THE CODES APPENDIX

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         CTGRY_EQTBL_BENE_IDENT_CD.

                                                         SOURCE:
                                                         BIC EQUATE MODULE

 11. Beneficiary Identification  CHAR     2    70   71  The code identifying the type of relationship between an
     Code                                                individual and a primary Social Security Administration
                                                         (SSA) beneficiary or a primary Railroad Board (RRB)
                                                         beneficiary.
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                         POSITIONS
           NAME                 TYPE  LENGTH BEG  END                              CONTENTS
    ---------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                         COMMON ALIAS: BIC
                                                         DA3 ALIAS: BENE_IDENT_CODE
                                                         DB2 ALIAS: BENE_IDENT_CD
                                                         SAS ALIAS: BIC
                                                         STANDARD ALIAS: BENE_IDENT_CD
                                                         TITLE ALIAS: BIC
```

carrier.txt

EDIT-RULES:
EDB REQUIRED FIELD

CODES:
  REFER TO: BENE_IDENT_TB
              IN THE CODES APPENDIX

SOURCE:
SSA/RRB

12. NCH State Segment Code   CHAR   1   72   72   The code identifying the segment of the NCH Nearline file
                                                             containing the beneficiary's record for a specific service
                                                             year. Effective 12/96, segmentation is by CLM_LCTR_NUM,
                                                             then final action sequence within residence state. (Prior
                                                             to 12/96, segmentation was by ranges of county codes within
                                                             the residence state.)

                                                             DB2 ALIAS: NCH_STATE_SGMT_CD
                                                             SAS ALIAS: ST_SGMT
                                                             STANDARD ALIAS: NCH_STATE_SGMT_CD
                                                             TITLE ALIAS: NEAR_LINE_SEGMENT
                                                             CODES:
                                                               REFER TO: NCH_STATE_SGMT_TB
                                                                           IN THE CODES APPENDIX

                                                             COMMENT:
                                                             Prior to Version H this field was named:
                                                             BENE_STATE_SGMT_NEAR_LINE_CD.

                                                             SOURCE:
                                                             NCH

13. Beneficiary Residence SSA   CHAR   2   73   74   The SSA standard state code of a beneficiary's residence.
    Standard State Code
                                                             DA3 ALIAS: SSA_STANDARD_STATE_CODE
                                                             DB2 ALIAS: BENE_SSA_STATE_CD
                                                             SAS ALIAS: STATE_CD
                                                             STANDARD ALIAS: BENE_RSDNC_SSA_STD_STATE_CD
                                                             TITLE ALIAS: BENE_STATE_CD

                                                             EDIT-RULES:
                                                             OPTIONAL: MAY BE BLANK

                                                             CODES:
                                                               REFER TO: GEO_SSA_STATE_TB
                                                                           IN THE CODES APPENDIX

```
                                         POSITIONS
            NAME                 TYPE  LENGTH BEG   END                        CONTENTS
----------------------------     ----  ------ ---------   -------------------------------------------------------------
```

                                                          COMMENT:
                                                          1. Used in conjunction with a county code, as
                                                             selection criteria for the determination of
                                                             payment rates for HMO reimbursement.
                                                          2. Concerning individuals directly billable for
                                                             Part B and/or Part A premiums, this element
                                                             is used to determine if the beneficiary
                                                             will receive a bill in English or Spanish.
                                                          3. Also used for special studies.

                                                          SOURCE:
                                                          SSA/EDB

14. Claim From Date   NUM   8   75   82 The first day on the billing statement
                                                          covering services rendered to the bene-
                                                          ficiary (a.k.a. 'Statement Covers From Date').

                                                          NOTE: For Home Health PPS claims, the 'from'
                                                          date and the 'thru' date on the RAP (initial
                                                          claim) must always match.

                                                          8 DIGITS UNSIGNED

                                                          DB2 ALIAS: CLM_FROM_DT
                                                          SAS ALIAS: FROM_DT
                                                          STANDARD ALIAS: CLM_FROM_DT
                                                          TITLE ALIAS: FROM_DATE

                                                          EDIT-RULES:
                                                          YYYYMMDD

                                                          SOURCE:
                                                          CWF

15. Claim Through Date   NUM   8   83   90 The last day on the billing statement covering
                                                          services rendered to the beneficiary (a.k.a
                                                          'Statement Covers Thru Date').

                                                          NOTE: For Home Health PPS claims, the 'from'
                                                          date and the 'thru' date on the RAP (initial
                                                          claim) must always match.

                                                          8 DIGITS UNSIGNED

                              DB2 ALIAS: CLM_THRU_DT
                              SAS ALIAS: THRU_DT
                              STANDARD ALIAS: CLM_THRU_DT
                              TITLE ALIAS: THRU_DATE

                              EDIT-RULES:
                              YYYYMMDD

                              SOURCE:
                              CWF
1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                    POSITIONS
             NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ --------- ---

    16. NCH Weekly Claim Processing NUM   8   91   98 The date the weekly NCH database load
        Date   process cycle begins, during which the claim
                                                            records are loaded into the Nearline file.
                                                            This date will always be a Friday, although
                                                            the claims will actually be appended to the
                                                            database subsequent to the date.

                                                            8 DIGITS UNSIGNED

                                                            DB2 ALIAS: NCH_WKLY_PROC_DT
                                                            SAS ALIAS: WKLY_DT
                                                            STANDARD ALIAS: NCH_WKLY_PROC_DT
                                                            TITLE ALIAS: NCH_PROCESS_DT

                                                            EDIT-RULES:
                                                            YYYYMMDD

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            HCFA_CLM_PROC_DT.

                                                            SOURCE:
                                                            NCH

    17. CWF Claim Accretion Date   NUM   8   99 106 The date the claim record is accreted (posted/
                                                            processed) to the beneficiary master record
                                                            at the CWF host site and authorization for
                                                            payment is returned to the fiscal interme-
                                                            diary or carrier.

                                                            8 DIGITS UNSIGNED

                                    Page 12

```
                                DB2 ALIAS: CWF_CLM_ACRTN_DT
                                SAS ALIAS: ACRTN_DT
                                STANDARD ALIAS: CWF_CLM_ACRTN_DT
                                TITLE ALIAS: ACCRETION_DT

                                EDIT-RULES:
                                YYYYMMDD

                                SOURCE:
                                CWF
```

18. CWF Claim Accretion Number   PACK   2   107 108   The sequence number assigned to the claim
                                                         record when accreted (posted/processed) to
                                                         the beneficiary master record at the CWF host
                                                         site on a given date. This element indicates
                                                         the position of the claim within that day's
                                                         processing at the CWF host. **(Exception: If
                                                         the claim record is missing the accretion date
                                                         HCFA's CWFMQA system places a zero in the
                                                         accretion number.

                                                         3 DIGITS SIGNED

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                                 POSITIONS
              NAME                     TYPE  LENGTH BEG   END                            CONTENTS
     ----------------------------      ----  ------ ---------   ------------------------------------------------------------
```

```
                                DB2 ALIAS: CWF_CLM_ACRTN_NUM
                                SAS ALIAS: ACRTN_NM
                                STANDARD ALIAS: CWF_CLM_ACRTN_NUM
                                TITLE ALIAS: ACCRETION_NUMBER

                                SOURCE:
                                CWF
```

19. Carrier Claim Control   CHAR   15   109 123   Unique control number assigned by a carrier
    Number   to a non-institutional claim.

                                                         COMMON ALIAS: CCN
                                                         DB2 ALIAS: CARR_CLM_CNTL_NUM
                                                         SAS ALIAS: CARRCNTL
                                                         STANDARD ALIAS: CARR_CLM_CNTL_NUM
                                                         TITLE ALIAS: CCN

                                                         EDIT-RULES:
                                                         LEFT JUSTIFY

carrier.txt
COMMENT:
For the physician/supplier or DMERC claim, this
field allows HCFA to associate each line item
with its respective claim.

SOURCE:
CWF

```
20. FILLER                        CHAR    38   124  161
```

```
21. NCH Daily Process Date        NUM      8   162  169
```
Effective with Version H, the date the claim record was
processed by HCFA's CWFMQA system (used for internal editing
purposes).

Effective with Version I, this date is used in conjunction
with the NCH Segment Link Number to keep claims with
multiple records/ segments together.

NOTE1: With Version 'H' this field was pop- ulated with
        data beginning with NCH weekly process date 10/3/97.
        Under Version 'I' claims prior to 10/3/97, that were
        blank under Version 'H', were populated with a date.

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_DAILY_PROC_DT
SAS ALIAS: DAILY_DT
STANDARD ALIAS: NCH_DAILY_PROC_DT
TITLE ALIAS: DAILY_PROCESS_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
NCH

Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

NAME	TYPE	LENGTH	POSITIONS BEG	END	CONTENTS
22. NCH Segment Link Number	PACK	5	170	174	Effective with Version 'I', the system gen- erated number used in conjunction with the NCH daily process date to keep records/segments belonging to a specific claim together. This field was added to ensure that records/ segments that come in on the same batch with the same identifying information in the link

group are not mixed with each other.

NOTE: During the Version I conversion this
        field was populated with data throughout
        history (back to service year 1991).

9 DIGITS SIGNED

DB2 ALIAS: NCH_SGMT_LINK_NUM
SAS ALIAS: LINK_NUM
STANDARD ALIAS: NCH_SGMT_LINK_NUM
TITLE ALIAS: LINK_NUM

SOURCE:
NCH

23. Claim Total Segment Count   NUM   2   175 176   Effective with Version I, the count used
                                                        to identify the total number of segments
                                                        associated with a given claim. Each claim
                                                        could have up to 10 segments.

                                                        NOTE: During the Version I conversion, this
                                                                field was populated with data throughout
                                                                history (back to service year 1991).
                                                                For institutional claims, the count
                                                                for claims prior to 7/00 will be 1 or 2
                                                                (1 if 45 or less revenue center lines on a
                                                                claim and 2 if more than 45 revenue center
                                                                lines on a claim). For noninstitutional
                                                                claims, the count will always be 1.

                                                        2 DIGITS UNSIGNED

                                                        DB2 ALIAS: TOT_SGMT_CNT
                                                        SAS ALIAS: SGMT_CNT
                                                        STANDARD ALIAS: CLM_TOT_SGMT_CNT
                                                        TITLE ALIAS: SEGMENT_COUNT

                                                        SOURCE:
                                                        CWF

24. Claim Segment Number   NUM   2   177 178   Effective with Version I, the number used
                                                        to identify an actual record/segment (1 - 10)
                                                        associated with a given claim.
1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                    POSITIONS
                NAME   TYPE LENGTH BEG END   CONTENTS

--------------------------- ---- ------ --------- --

```
                                       NOTE:  During the Version I conversion this
                                              field was populated with data throughout
                                              history (back to service year 1991).
                                              For institutional claims prior to 7/00,
                                              this number will be either 1 or 2.  For
                                              noninstitutional claims, the number will
                                              always be 1.

                                       2 DIGITS UNSIGNED

                                       DB2 ALIAS: CLM_SGMT_NUM
                                       SAS ALIAS: SGMT_NUM
                                       STANDARD ALIAS: CLM_SGMT_NUM
                                       TITLE ALIAS: SEGMENT_NUMBER

                                       SOURCE:
                                       CWF

25. Claim Total Line Count     NUM    3   179  181  Effective with Version I, the count used to
                                                    identify the total number of revenue center
                                                    lines associated with the claim.

                                       NOTE:  During the Version I conversion this
                                              field was populated with data throughout
                                              history (back to service year 1991).
                                              Prior to Version 'I', the maximum line count
                                              will be no more than 58.  Effective with Version
                                              'I', the maximum line count could be 450.

                                       3 DIGITS UNSIGNED

                                       DB2 ALIAS: TOT_LINE_CNT
                                       SAS ALIAS: LINECNT
                                       STANDARD ALIAS: CLM_TOT_LINE_CNT
                                       TITLE ALIAS: TOTAL_LINE_COUNT

                                       SOURCE:
                                       CWF

26. Claim Segment Line Count   NUM    2   182  183  Effective with Version I, the count used
                                                    to identify the number of revenue center
                                                    lines on a record/segment.

                                       NOTE:  During the Version I conversion this
                                              field was populated with data throughout
                                              history (back to service year 1991).
```

The maximum line count per record/segment
is 45.

2 DIGITS UNSIGNED
1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

DB2 ALIAS: SGMT_LINE_CNT
SAS ALIAS: SGMTLINE
STANDARD ALIAS: CLM_SGMT_LINE_CNT
TITLE ALIAS: SEGMENT_LINE_COUNT

SOURCE:
CWF

**** Carrier/DMERC Claim Common   GROUP   194   184 377   Information common to both carrier and
     1 Group   DMERC claims for version I of NCH.

                                                            STANDARD ALIAS: CARR_DMERC_CLM_CMN_1_GRP

27. FILLER   CHAR   5   184 188

28. Carrier Claim Entry Code   CHAR   1   189 189   Carrier-generated code describing whether the
                                                            Part B claim is an original debit, full credit,
                                                            or replacement debit.

                                                            DB2 ALIAS: CARR_CLM_ENTRY_CD
                                                            SAS ALIAS: ENTRY_CD
                                                            STANDARD ALIAS: CARR_CLM_ENTRY_CD
                                                            TITLE ALIAS: ENTRY_CD

                                                            CODES:
                                                            1 = Original debit; void of original debit
                                                                (If CLM_DISP_CD = 3, code 1 means
                                                                voided original debit)
                                                            3 = Full credit
                                                            5 = Replacement debit
                                                            9 = Accrete bill history only (internal;
                                                                effective 2/22/91)

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            CWFB_CLM_ENTRY_CD.

                                                            SOURCE:

```
  29. FILLER                      CHAR     1   190  190

  30. Claim Disposition Code      CHAR     2   191  192   Code indicating the disposition or outcome of the processing
                                                          of the claim record.

                                                          DB2 ALIAS: CLM_DISP_CD
                                                          SAS ALIAS: DISP_CD
                                                          STANDARD ALIAS: CLM_DISP_CD
                                                          TITLE ALIAS: DISPOSITION_CD

                                                          CODES:
                                                            REFER TO: CLM_DISP_TB
                                                              IN THE CODES APPENDIX
1                          Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                        POSITIONS
            NAME                 TYPE   LENGTH BEG   END                           CONTENTS
  ---------------------------    ----   ------ ---------   -------------------------------------------------------------

                                                          SOURCE:
                                                          CWF

  31. NCH Edit Disposition Code  CHAR     2   193  194   Effective with Version H, a code used (for internal editing
                                                          purposes) to indicate the disposition of the claim after
                                                          editing in the CWFMQA process.

                                                          NOTE:   Beginning with NCH weekly process date 10/3/97 this
                                                                  field was populated with data. Claims processed prior
                                                                  to 10/3/97 will contain spaces in this field.

                                                          DB2 ALIAS: NCH_EDIT_DISP_CD
                                                          SAS ALIAS: EDITDISP
                                                          STANDARD ALIAS: NCH_EDIT_DISP_CD
                                                          TITLE ALIAS: NCH_EDIT_DISP

                                                          CODES:
                                                          00 = No MQA errors
                                                          10 = Possible duplicate
                                                          20 = Utilization error
                                                          30 = Consistency error
                                                          40 = Entitlement error
                                                          50 = Identification error
                                                          60 = Logical duplicate
                                                          70 = Systems duplicate

                                                          SOURCE:
```

32. NCH Claim BIC Modify H Code   CHAR   1   195 195   Effective with Version H, the code used (for internal
                                                         editing purposes) to identify a claim record that was
                                                         submitted with an incorrect HA, HB, or HC BIC.

                                                         NOTE: Beginning with NCH weekly process date 10/3/97 this
                                                                field was populated with data.   Claims processed
                                                                prior to 10/3/97 will contain spaces in this field.

                                                         DB2 ALIAS: NCH_BIC_MDFY_CD
                                                         SAS ALIAS: BIC_MDFY
                                                         STANDARD ALIAS: NCH_CLM_BIC_MDFY_CD
                                                         TITLE ALIAS: BIC_MODIFY_CD

                                                         CODES:
                                                         H = BIC submitted by CWF = HA, HB or HC
                                                         blank = No HA, HB or HC BIC present

                                                         SOURCE:
                                                         NCH QA Process

33. Beneficiary Residence SSA   CHAR   3   196 198   The SSA standard county code of a beneficiary's residence.
    Standard County Code

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                      POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ --------- ---

                                                         DA3 ALIAS: SSA_STANDARD_COUNTY_CODE
                                                         DB2 ALIAS: BENE_SSA_CNTY_CD
                                                         SAS ALIAS: CNTY_CD
                                                         STANDARD ALIAS: BENE_RSDNC_SSA_STD_CNTY_CD
                                                         TITLE ALIAS: BENE_COUNTY_CD

                                                         EDIT-RULES:
                                                         OPTIONAL: MAY BE BLANK

                                                         SOURCE:
                                                         SSA/EDB

34. Carrier Claim Receipt Date   NUM   8   199 206   The date the carrier receives the non-
                                                         institutional claim.

                                                         8 DIGITS UNSIGNED

                                                         DB2 ALIAS: CARR_CLM_RCPT_DT

```
                                    carrier.txt
                                  SAS ALIAS: RCPT_DT
                                  STANDARD ALIAS: CARR_CLM_RCPT_DT
                                  TITLE ALIAS: RECEIPT_DT

                                  EDIT-RULES:
                                  YYYYMMDD

                                  COMMENT:
                                  Prior to Version H this field was named:
                                  FICARR_CLM_RCPT_DT.

                                  SOURCE:
                                  CWF

35. Carrier Claim Scheduled    NUM     8   207  214   The scheduled date of payment to the physician
    Payment Date                                      or supplier, as appearing on the original non-
                                                      institutional claim sent to the CWF host.
                                                      **Note:  This date is considered to be the
                                                      date paid since no additional information as
                                                      to the actual payment date is available.

                                                      8 DIGITS UNSIGNED

                                                      DB2 ALIAS: CARR_SCHLD_PMT_DT
                                                      SAS ALIAS: SCHLD_DT
                                                      STANDARD ALIAS: CARR_CLM_SCHLD_PMT_DT
                                                      TITLE ALIAS: SCHLD_PMT_DT

                                                      EDIT-RULES:
                                                      YYYYMMDD

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      FICARR_CLM_PMT_DT.
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                                POSITIONS
              NAME                  TYPE  LENGTH BEG   END                          CONTENTS
------------------------------      ----  ------ --------- ------------------------------------------------------------

                                                      SOURCE:
                                                      CWF

36. CWF Forwarded Date         NUM     8   215  222   Effective with Version H, the date CWF forwarded the claim
                                                      record to HCFA (used for internal editing purposes).

                                                      NOTE:  Beginning with NCH weekly process date 10/3/97 this
```

carrier.txt
  field was populated with data. Claims processed
  prior to 10/3/97 will contain zeroes in this field.

8 DIGITS UNSIGNED

DB2 ALIAS: CWF_FRWRD_DT
SAS ALIAS: FRWRD_DT
STANDARD ALIAS: CWF_FRWRD_DT
TITLE ALIAS: FORWARD_DT

EDIT-RULES:
YYYYMMDD

SOURCE:
CWF

| 37. Carrier Number | CHAR | 5 | 223 | 227 | The identification number assigned by HCFA to a carrier authorized to process claims from a physician or supplier. |

DB2 ALIAS: CARR_NUM
SAS ALIAS: CARR_NUM
STANDARD ALIAS: CARR_NUM
SYSTEM ALIAS: LTCARR
TITLE ALIAS: CARRIER

CODES:
  REFER TO: CARR_NUM_TB
        IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
FICARR_IDENT_NUM.

SOURCE:
CWF

| 38. FILLER | CHAR | 8 | 228 | 235 | |

| 39. CWF Transmission Batch Number | CHAR | 4 | 236 | 239 | Effective with Version H, the number assigned to each batch of claims transactions sent from CWF(used for internal editing purposes). |

NOTE: Beginning 11/98, this field will be
      populated with data. Claims processed
      prior to 11/98 will contain spaces in
      this field.

```
                                          POSITIONS
          NAME                 TYPE  LENGTH BEG   END                         CONTENTS
----------------------------   ----  ------ ---------   -------------------------------------------------------
                                                        DB2 ALIAS: TRNSMSN_BATCH_NUM
                                                        SAS ALIAS: FIBATCH
                                                        STANDARD ALIAS: CWF_TRNSMSN_BATCH_NUM
                                                        TITLE ALIAS: BATCH_NUM

                                                        SOURCE:
                                                        CWF

40. Beneficiary Mailing Contact  CHAR    9    240   248  The ZIP code of the mailing address where the
    ZIP Code                                             beneficiary may be contacted.

                                                        DB2 ALIAS: BENE_MLG_ZIP_CD
                                                        SAS ALIAS: BENE_ZIP
                                                        STANDARD ALIAS: BENE_MLG_CNTCT_ZIP_CD
                                                        TITLE ALIAS: BENE_ZIP

                                                        SOURCE:
                                                        EDB

41. Beneficiary Sex              CHAR    1    249   249  The sex of a beneficiary.
    Identification Code
                                                        COMMON ALIAS: SEX_CD
                                                        DA3 ALIAS: SEX_CODE
                                                        DB2 ALIAS: BENE_SEX_IDENT_CD
                                                        SAS ALIAS: SEX
                                                        STANDARD ALIAS: BENE_SEX_IDENT_CD
                                                        SYSTEM ALIAS: LTSEX
                                                        TITLE ALIAS: SEX_CD

                                                        EDIT-RULES:
                                                        REQUIRED FIELD

                                                        CODES:
                                                        1 = Male
                                                        2 = Female
                                                        0 = Unknown

                                                        SOURCE:
                                                        SSA,RRB,EDB

42. Beneficiary Race Code        CHAR    1    250   250  The race of a beneficiary.

                                                        DA3 ALIAS: RACE_CODE
```

Page 22

DB2 ALIAS: BENE_RACE_CD
SAS ALIAS: RACE
STANDARD ALIAS: BENE_RACE_CD
SYSTEM ALIAS: LTRACE
TITLE ALIAS: RACE_CD

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                          POSITIONS
              NAME               TYPE  LENGTH BEG  END                             CONTENTS
   ----------------------------  ----  ------ ---------  ------------------------------------------------------------

                                                       CODES:
                                                       0 = Unknown
                                                       1 = White
                                                       2 = Black
                                                       3 = Other
                                                       4 = Asian
                                                       5 = Hispanic
                                                       6 = North American Native

                                                       SOURCE:
                                                       SSA

   43. Beneficiary Birth Date    NUM      8    251  258  The beneficiary's date of birth.

                                                       8 DIGITS UNSIGNED

                                                       DB2 ALIAS: BENE_BIRTH_DT
                                                       SAS ALIAS: BENE_DOB
                                                       STANDARD ALIAS: BENE_BIRTH_DT
                                                       TITLE ALIAS: BENE_BIRTH_DATE

                                                       EDIT-RULES:
                                                       YYYYMMDD

                                                       SOURCE:
                                                       CWF

   44. CWF Beneficiary Medicare  CHAR     2    259  260  The CWF-derived reason for a beneficiary's
       Status Code                                       entitlement to Medicare benefits, as of the
                                                         reference date (CLM_THRU_DT).

                                                       COBOL ALIAS: MSC
                                                       COMMON ALIAS: MSC
                                                       DB2 ALIAS: BENE_MDCR_STUS_CD
                                                       SAS ALIAS: MS_CD
                                                       STANDARD ALIAS: CWF_BENE_MDCR_STUS_CD
```

```
                          carrier.txt
                     SYSTEM ALIAS: LTMSC
                     TITLE ALIAS: MSC

                     DERIVATION:
                     CWF derives MSC from the following:
                       1.  Date of Birth
                       2.  Claim Through Date
                       3.  Original/Current Reasons for entitlement
                       4.  ESRD Indicator
                       5.  Beneficiary Claim Number
                     Items 1,3,4,5 come from the CWF Beneficiary
                     Master Record; item 2 comes from the FI/Carrier
                     claim record.  MSC is assigned as follows:
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                POSITIONS
        NAME                  TYPE  LENGTH BEG  END                          CONTENTS
-----------------------------  ----  ------ ---------  -------------------------------------------------------------
```

MSC	OASI	DIB	ESRD	AGE	BIC
10	YES	N/A	NO	65 and over	N/A
11	YES	N/A	YES	65 and over	N/A
20	NO	YES	NO	under 65	N/A
21	NO	YES	YES	under 65	N/A
31	NO	NO	YES	any age	T.

```
                     CODES:
                     10 = Aged without ESRD
                     11 = Aged with ESRD
                     20 = Disabled without ESRD
                     21 = Disabled with ESRD
                     31 = ESRD only

                     COMMENT:
                     Prior to Version H this field was named:
                     BENE_MDCR_STUS_CD.  The name has been changed
                     to distinguish this CWF-derived field from the
                     EDB-derived MSC (BENE_MDCR_STUS_CD).

                     SOURCE:
                     CWF
```

```
    45. Claim Patient 6 Position   CHAR    6   261  266  The first 6 positions of the Medicare patient's
        Surname                                          surname (last name) as reported by the provider
                                                         on the claim.
```

carrier.txt

NOTE1: Prior to Version H, this field was only
       present on the IP/SNF claim record.
       Effective with Version H, this field is
       present on all claim types.

NOTE2: For OP, HHA, Hospice and all Carrier
       claims, data was populated beginning
       with NCH weekly process 10/3/97. Claims
       processed prior to 10/3/97 will contain
       spaces in this field.

COMMON ALIAS: PATIENT_SURNAME
DB2 ALIAS: PTNT_6_PSTN_SRNM
SAS ALIAS: SURNAME
STANDARD ALIAS: CLM_PTNT_6_PSTN_SRNM_NAME
TITLE ALIAS: PATIENT_SURNAME

SOURCE:
CWF

46. Claim Patient 1st Initial   CHAR   1   267 267   The first initial of the Medicare patient's
    Given Name   given name (first name) as reported by the
                                                         provider on the claim.

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                              POSITIONS
              NAME   TYPE LENGTH BEG   END   CONTENTS
    ---------------------------- ---- ------ --------- ---

                                                       NOTE1: Prior to Version H, this field was only
                                                              present on the IP/SNF claim record.
                                                              Effective with Version H, this field
                                                              is present on all claim types.

                                                       NOTE2: For OP, HHA, Hospice and all Carrier claims,
                                                              data was populated beginning with NCH
                                                              weekly process date 10/3/97. Claims
                                                              processed prior to 10/3/97 will contain
                                                              spaces in this field.

                                                       COMMON ALIAS: PATIENT_GIVEN_NAME
                                                       DB2 ALIAS: 1ST_INITL_GVN_NAME
                                                       SAS ALIAS: FRSTINIT
                                                       STANDARD ALIAS: CLM_PTNT_1ST_INITL_GVN_NAME
                                                       TITLE ALIAS: PATIENT_FIRST_INITIAL

                                                       SOURCE:

                                                          Page 25

47. Claim Patient First Initial   CHAR   1   268 268   The first initial of the Medicare patient's
    Middle Name   middle name as reported by the provider on
                                                         the claim.

                                                         NOTE1:   Prior to Version H, this field was only
                                                                  present on the IP/SNF claim record.
                                                                  Effective with Version H, this field is
                                                                  present on all claim types.

                                                         NOTE2:   For OP, HHA, Hospice and all Carrier claims,
                                                                  data was populated beginning with NCH
                                                                  weekly process date 10/3/97.   Claims pro-
                                                                  cessed prior to 10/3/97 will contain
                                                                  spaces in this field.

                                                         COMMON ALIAS: PATIENT_MIDDLE_NAME
                                                         DB2 ALIAS: 1ST_INITL_MDL_NAME
                                                         SAS ALIAS: MDL_INIT
                                                         STANDARD ALIAS: CLM_PTNT_1ST_INITL_MDL_NAME
                                                         TITLE ALIAS: PATIENT_MIDDLE_INITIAL

                                                         SOURCE:
                                                         CWF

48. Beneficiary CWF Location   CHAR   1   269 269   The code that identifies the Common Working File
    Code   (CWF) location (the host site) where a beneficiary's
                                                         Medicare utilization records are maintained.

                                                         COMMON ALIAS: CWF_HOST
                                                         DB2 ALIAS: BENE_CWF_LOC_CD
                                                         SAS ALIAS: CWFLOCCD
                                                         STANDARD ALIAS: BENE_CWF_LOC_CD
                                                         SYSTEM ALIAS: LTCWFLOC
                                                         TITLE ALIAS: CWF_HOST

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                       POSITIONS
              NAME   TYPE LENGTH BEG   END   CONTENTS
    ---------------------------- ---- ------ --------- ---

                                                         CODES:
                                                         B = Mid-Atlantic
                                                         C = Southwest
                                                         D = Northeast
                                                         E = Great Lakes
                                                         F = Great Western

G = Keystone
H = Southeast
I = South
J = Pacific

SOURCE:
CWF

49. Claim Principal Diagnosis   CHAR   5   270 274   The ICD-9-CM diagnosis code identifying the diagnosis,
    Code   condition, problem or other reason for the
admission/encounter/visit shown in the medical record to be
chiefly responsible for the services provided.

NOTE: Effective with Version H, this data is also
redundantly stored as the first occurrence of the diagnosis
trailer.

DB2 ALIAS: PRNCPAL_DGNS_CD
SAS ALIAS: PDGNS_CD
STANDARD ALIAS: CLM_PRNCPAL_DGNS_CD
TITLE ALIAS: PRINCIPAL_DIAGNOSIS

EDIT-RULES:
ICD-9-CM

SOURCE:
CWF

50. FILLER   CHAR   1   275 275

51. Carrier Claim Payment   CHAR   1   276 276   The code on a noninstitutional claim indicating to
    Denial Code   whom payment was made or if the claim was denied.

DB2 ALIAS: CARR_PMT_DNL_CD
SAS ALIAS: PMTDNLCD
STANDARD ALIAS: CARR_CLM_PMT_DNL_CD
TITLE ALIAS: PMT_DENIAL_CD

CODES:
   REFER TO: CARR_CLM_PMT_DNL_TB
              IN THE CODES APPENDIX

COMMENT:
Prior to Version H this field was named:
CWFB_CLM_PMT_DNL_CD.

SOURCE:
CWF

```
                                         POSITIONS
              NAME              TYPE  LENGTH BEG  END                          CONTENTS
-----------------------------  ----  ------ ---------  -------------------------------------------------------------

52. Claim Excepted/Nonexcepted  CHAR    1   277  277   Effective with Version I, the code used to identify
    Medical Treatment Code                             whether or not the medical care or treatment received
                                                       by a beneficiary, who has elected care from a
                                                       Religious Nonmedical Health Care Institution (RNHCI),
                                                       is excepted or nonexcepted.  Excepted is medical care
                                                       or treatment that is received involuntarily or is re-
                                                       quired under Federal, State or local law. Nonexcepted is
                                                       defined as medical care or treatment other than excepted.

                                                       DB2 ALIAS: EXCPTD_NEXCPTD_CD
                                                       SAS ALIAS: TRTMT_CD
                                                       STANDARD ALIAS: CLM_EXCPTD_NEXCPTD_TRTMT_CD
                                                       TITLE ALIAS: EXCPTD_NEXCPTD_CD

                                                       CODES:
                                                       0 = No Entry
                                                       1 = Excepted
                                                       2 = Nonexcepted

                                                       SOURCE:
                                                       CWF

53. Claim Payment Amount        PACK    6   278  283   Amount of payment made from the Medicare trust fund for the
                                                       services covered by the claim record.  Generally, the amount
                                                       is calculated by the FI or carrier; and represents what was
                                                       paid to the institutional provider, physician, or supplier,
                                                       with the exceptions noted below.  **NOTE:  In some
                                                       situations, a negative claim payment amount may be pre-
                                                       sent; e.g., (1) when a beneficiary is charged the full
                                                       deductible during a short stay and the deductible exceeded
                                                       the amount Medicare pays; or (2) when a beneficiary is
                                                       charged a coinsurance amount during a long stay and the
                                                       coinsurance amount exceeds the amount Medicare pays (most
                                                       prevalent situation involves psych hospitals who are paid a
                                                       daily per diem rate no matter what the charges are.)

                                                       Under IP PPS, inpatient hospital services are paid based on
                                                       a predetermined rate per discharge, using the DRG patient
                                                       classification system and the PRICER program.   On the IP
                                                       PPS claim, the payment amount includes the DRG outlier
                                                       approved payment amount, disproportionate share (since
                                                       5/1/86), indirect medical education (since 10/1/88), total
```

PPS capital (since 10/1/91). It does NOT include the pass
thru amounts (i.e., capital-related costs, direct medical
education costs, kidney acquisition costs, bad debts); or
any beneficiary-paid amounts (i.e., deductibles and
coinsurance); or any other payer reimbursement.

Under SNF PPS, SNFs will classify beneficiaries using the
patient classification system known as RUGS III. For the
SNF PPS claim, the SNF PRICER will calculate/return the rate
for each revenue center line item with revenue center code =
'0022'; multiply the rate times the units count; and then
sum the amount payable for all lines with revenue center
code '0022' to determine the total claim payment amount.

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                     POSITIONS
         NAME              TYPE  LENGTH BEG  END                          CONTENTS
---------------------------  ----  ------ ---------  ------------------------------------------------------------
```

Under Outpatient PPS, the national ambulatory payment
classification (APC) rate that is calculated for each APC
group is the basis for determining the total payment. The
Medicare payment amount takes into account the wage index
adjustment and the beneficiary deductible and coinsurance
amounts. NOTE: There is no CWF edit check to validate that
the revenue center Medicare payment amount equals the claim
level Medicare payment amount.

Under Home Health PPS, beneficiaries will be classified into
an appropriate case mix category known as the Home Health
Resource Group. A HIPPS code is then generated
corresponding to the case mix category (HHRG).

For the RAP, the PRICER will determine the payment amount
appropriate to the HIPPS code by computing 60% (for first
episode) or 50% (for subsequent episodes) of the case mix
episode payment. The payment is then wage index adjusted.

For the final claim, PRICER calculates 100% of the amount
due, because the final claim is processed as an adjustment
to the RAP, reversing the RAP payment in full. Although
final claim will show 100% payment amount, the provider will
actually receive the 40% or 50% payment.

Exceptions: For claims involving demos and BBA encounter
data, the amount reported in this field may not just
represent the actual provider payment.

carrier.txt
For demo Ids '01','02','03','04' -- claims contain
amount paid to the provider, except that special
'differentials' paid outside the normal payment system
are not included.

For demo Ids '05','15' -- encounter data 'claims'
contain amount Medicare would have paid under FFS,
instead of the actual payment to the MCO.

For demo Ids '06','07','08' -- claims contain actual
provider payment but represent a special negotiated
bundled payment for both Part A and Part B services.
To identify what the conventional provider Part A
payment would have been, check value code = 'Y4'.   The
related noninstitutional (physician/supplier) claims
contain what would have been paid had there been no
demo.

For BBA encounter data (non-demo) -- 'claims' contain
amount Medicare would have paid under FFS, instead of
the actual payment to the BBA plan.

9.2 DIGITS SIGNED

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                        POSITIONS
            NAME   TYPE LENGTH BEG   END   CONTENTS
----------------------------   ---- ------ ---------   ---

                                                            COMMON ALIAS: REIMBURSEMENT
                                                            DB2 ALIAS: CLM_PMT_AMT
                                                            SAS ALIAS: PMT_AMT
                                                            STANDARD ALIAS: CLM_PMT_AMT
                                                            TITLE ALIAS: REIMBURSEMENT

                                                            EDIT-RULES:
                                                            $$$$$$$$$CC

                                                            COMMENT:
                                                            Prior to Version H the size of this field was S9(7)V99. Als
                                                            the noninstitutional claim records carried this field as a l
                                                            item. Effective with Version H, this element is a claim lev
                                                            field across all claim types (and the line item field has be
                                                            renamed.)

                                                            SOURCE:
                                                                   Page 30

CWF

LIMITATIONS:
Prior to 4/6/93, on inpatient, outpatient, and
physician/supplier claims containing a
CLM_DISP_CD of '02', the amount shown as the Medicare
reimbursement does not take into consideration
any CWF automatic adjustments (involving erroneous
deductibles in most cases). In as many as 30% of
the claims (30% IP, 15% OP, 5% PART B), the
reimbursement reported on the claims may be over
or under the actual Medicare payment amount.

54. Carrier Claim Primary Payer PACK   6   284 289 Effective with Version H, the amount of a
    Paid Amount   payment made on behalf of a Medicare bene-
                                                         ficiary by a primary payer other than Medicare,
                                                         that the provider is applying to covered
                                                         Medicare charges on a non-institutional claim.

                                                         NOTE: During the Version H conversion, this field
                                                         was populated with data throughout history (back to
                                                         service year 1991) by summing up the line item primary
                                                         payer amounts.

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: CARR_PRMRY_PYR_AMT
                                                         SAS ALIAS: PRPAYAMT
                                                         STANDARD ALIAS: CARR_CLM_PRMRY_PYR_PD_AMT
                                                         TITLE ALIAS: PRIMARY_PAYER_AMOUNT

                                                         EDIT-RULES:
                                                         $$$$$$$$$CC

                                                         SOURCE:
                                                         CWF

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                          POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------   ---- ------ --------- --

55. FILLER   CHAR   1   290 290

56. Carrier Claim Referring   CHAR   6   291 296 The unique physician identification number
    UPIN Number   (UPIN) of the physician who referred the
                                                          beneficiary to the physician who performed
                                                          the Part B services.

```
                            COMMON ALIAS: REFERRING_PHYSICIAN_UPIN
                            DB2 ALIAS: CARR_RFRG_UPIN_NUM
                            SAS ALIAS: RFR_UPIN
                            STANDARD ALIAS: CARR_CLM_RFRG_UPIN_NUM
                            TITLE ALIAS: REFERRING_PHYSICIAN_UPIN

                            COMMENT:
                            Prior to Version H this field was named:
                            CWFB_CLM_RFRG_UPIN_NUM.

                            SOURCE:
                            CWF
```

57. Carrier Claim Referring   CHAR   10   297   306   A placeholder field (effective with Version H)
    Physician NPI Number   for storing the NPI assigned to the referring
                                                          physician.

```
                            COMMON ALIAS: REFERRING_PHYSICIAN_NPI
                            DB2 ALIAS: RFRG_PHYSN_NPI_NUM
                            SAS ALIAS: RFR_NPI
                            STANDARD ALIAS: CARR_CLM_RFRG_PHYSN_NPI_NUM
                            TITLE ALIAS: RFRG_PHYSN_NPI

                            SOURCE:
                            CWF
```

58. Carrier Claim Provider   CHAR   1   307   307   A switch indicating whether or not the provider
    Assignment Indicator Switch   accepts assignment for the noninstitutional claim.

```
                            DB2 ALIAS: PRVDR_ASGNMT_SW
                            SAS ALIAS: ASGMNTCD
                            STANDARD ALIAS: CARR_CLM_PRVDR_ASGNMT_IND_SW
                            TITLE ALIAS: ASSIGNMENT_SW

                            CODES:
                            A = Assigned claim
                            N = Non-assigned claim

                            COMMENT:
                            Prior to Version H this field was named:
                            CWFB_CLM_PRVDR_ASGNMT_IND_SW.

                            SOURCE:
                            CWF
```

```
                                    POSITIONS
            NAME            TYPE  LENGTH BEG  END                            CONTENTS
 -------------------------   ----  ------ ---------  ------------------------------------------------------------
```

59. NCH Claim Provider Payment   PACK   6   308 313   Effective with Version H, the total payments
    Amount   made to the provider for this claim (sum of
                                                           line item provider payment amounts.)

                                                           NOTE: Beginning with NCH weekly process date
                                                           10/3/97 this field was populated with data.
                                                           Claims processed prior to 10/3/97 will contain
                                                           zeroes in this field.

                                                           9.2 DIGITS SIGNED

                                                           DB2 ALIAS: NCH_PRVDR_PMT_AMT
                                                           SAS ALIAS: PROV_PMT
                                                           STANDARD ALIAS: NCH_CLM_PRVDR_PMT_AMT
                                                           TITLE ALIAS: PRVDR_PMT

                                                           SOURCE:
                                                           NCH QA Process

60. NCH Claim Beneficiary   PACK   6   314 319   Effective with Version H, the total payments
    Payment Amount   made to the beneficiary for this claim (sum of
                                                           line payment amounts to the beneficiary.)
                                                           NOTE: Beginning with NCH weekly process date
                                                           10/3/97 this field was populated with data.
                                                           Claims processed prior to 10/3/97 will contain
                                                           zeroes in this field.

                                                           9.2 DIGITS SIGNED

                                                           DB2 ALIAS: NCH_BENE_PMT_AMT
                                                           SAS ALIAS: BENE_PMT
                                                           STANDARD ALIAS: NCH_CLM_BENE_PMT_AMT
                                                           TITLE ALIAS: BENE_PMT

                                                           SOURCE:
                                                           NCH QA Process

61. Carrier Claim Beneficiary   PACK   6   320 325   Effective with Version H, the amount paid by
    Paid Amount   the beneficiary for the non-institutional Part B
                                                           services.

                                                           NOTE: Beginning with NCH weekly process date
                                                           10/3/97 this field was populated with data.
                                                           Claims processed prior to 10/3/97 will contain
```

carrier.txt
zeroes in this field.

9.2 DIGITS SIGNED

DB2 ALIAS: CARR_BENE_PD_AMT
SAS ALIAS: BENEPAID
STANDARD ALIAS: CARR_CLM_BENE_PD_AMT
TITLE ALIAS: BENE_PD_AMT

SOURCE:
CWF

```
                                            POSITIONS
            NAME              TYPE  LENGTH BEG  END                         CONTENTS
----------------------------  ----  ------ ---------  ------------------------------------------------------------

  62. NCH Carrier Claim Submitted  PACK     6   326  331  Effective with Version H, the total submitted
      Charge Amount                                       charges on the claim (the sum of line item
                                                          submitted charges).

                                                          NOTE:  During the Version H conversion this field
                                                          was populated with data throughout history (back to
                                                          service year 1991).

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: CARR_SBMT_CHRG_AMT
                                                          SAS ALIAS: SBMTCHRG
                                                          STANDARD ALIAS: NCH_CARR_SBMT_CHRG_AMT
                                                          TITLE ALIAS: SBMT_CHRG

                                                          EDIT-RULES:
                                                          $$$$$$$$$CC

                                                          SOURCE:
                                                          NCH QA Process

  63. NCH Carrier Claim Allowed    PACK     6   332  337  Effective with Version H, the total allowed
      Charge Amount                                       charges on the claim (the sum of line item
                                                          allowed charges).

                                                          NOTE:  During the Version H conversion this field
                                                          was populated with data throughout history (back to
                                                          service year 1991).

                                                          9.2 DIGITS SIGNED
```

```
                      DB2 ALIAS: CARR_ALOW_CHRG_AMT
                      SAS ALIAS: ALOWCHRG
                      STANDARD ALIAS: NCH_CARR_ALOW_CHRG_AMT
                      TITLE ALIAS: ALOW_CHRG

                      EDIT-RULES:
                      $$$$$$$CC

                      SOURCE:
                      NCH QA Process
```

64. Carrier Claim Cash   PACK   6   338 343   Effective with Version H, the amount of the cash
    Deductible Applied Amount   deductible as submitted on the claim.

                      NOTE: Beginning with NCH weekly process date
                      10/3/97 this field was populated with data.
                      Claims processed prior to 10/3/97 will contain
                      zeroes in this field.

                      9.2 DIGITS SIGNED

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
----------------------------	----	------	---------		---

```
                      DB2 ALIAS: CASH_DDCTBL_AMT
                      SAS ALIAS: DEDAPPLY
                      STANDARD ALIAS: CARR_CLM_CASH_DDCTBL_APPLY_AMT
                      TITLE ALIAS: CASH_DDCTBL

                      SOURCE:
                      CWF
```

65. Carrier Claim HCPCS Year NUM   1   344 344   Effective with Version H, the terminal digit
    Code   of HCPCS version used to code the claim.

                      NOTE: Beginning with NCH weekly process date
                      10/3/97 this field was populated with data.
                      Claims processed prior to 10/3/97 will contain
                      zeroes in this field.

                      1 DIGIT UNSIGNED

                      DB2 ALIAS: CARR_HCPCS_YR_CD
                      SAS ALIAS: HCPCS_YR
                      STANDARD ALIAS: CARR_CLM_HCPCS_YR_CD
```

carrier.txt
TITLE ALIAS: HCPCS_YR

SOURCE:
CWF

66. Carrier Claim MCO Override   CHAR   1   345 345   Effective with Version H, the code used to
    Indicator Code   indicate whether or not an MCO investigation
                                                            applies to the claim (used for internal CWFMQA
                                                            editing purposes).

                                                            NOTE: Beginning with NCH weekly process date
                                                            10/3/97 this field was populated with data.
                                                            Claims processed prior to 10/3/97 will contain
                                                            spaces in this field.

                                                            DB2 ALIAS: MCO_OVRRD_IND_CD
                                                            SAS ALIAS: MCOOVRRD
                                                            STANDARD ALIAS: CARR_CLM_MCO_OVRRD_IND_CD
                                                            TITLE ALIAS: MCO_OVERRIDE

                                                            CODES:
                                                            0 = No Investigation
                                                            1 = MCO Investigation does not apply to this
                                                                claim.

                                                            SOURCE:
                                                            CWF

67. Carrier Claim Hospice   CHAR   1   346 346   Effective with Version H, the code used to
    Override Indicator Code   indicate whether or not an Hospice investigation
                                                            applies to the claim (used for internal CWFMQA
                                                            editing purposes).

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                            POSITIONS
                 NAME   TYPE LENGTH BEG END   CONTENTS
    ----------------------------   ---- ------ ---------   --

                                                            NOTE: Beginning with NCH weekly process date
                                                            10/3/97 this field was populated with data.
                                                            Claims processed prior to 10/3/97 will contain
                                                            spaces in this field.

                                                            DB2 ALIAS: HOSPC_OVRRD_IND_CD
                                                            SAS ALIAS: HOSPOVRD
                                                            STANDARD ALIAS: CARR_CLM_HOSPC_OVRRD_IND_CD
                                                            TITLE ALIAS: HOSPC_OVERRIDE

carrier.txt

```
CODES:
0 = No Investigation
1 = Hospice investigation shown not applicable
  to this claim.

SOURCE:
CWF
```

```
     68.  FILLER                      CHAR    31   347  377

   ****  Carrier Specific Group       GROUP   34   378  411   This group identifies those fields specific
                                                              to the carrier claim record.

                                                              STANDARD ALIAS: CARR_SPECFC_GRP

     69.  Carrier Claim Referring PIN  CHAR   14   378  391   Carrier-assigned identification (profiling)
          Number                                              number of the physician who referred the
                                                              beneficiary to the physician that performed
                                                              the Part B services.

                                                              COMMON ALIAS: REFERRING_PHYSICIAN_PIN
                                                              DB2 ALIAS: CARR_RFRG_PIN_NUM
                                                              SAS ALIAS: RFR_PRFL
                                                              STANDARD ALIAS: CARR_CLM_RFRG_PIN_NUM
                                                              TITLE ALIAS: RFRG_PIN

                                                              COMMENT:
                                                              Prior to Version H this field was named:
                                                              CWFB_CLM_RFRG_PHYSN_PRFLG_NUM.

                                                              SOURCE:
                                                              CWF

     70.  Care Plan Oversight (CPO)   CHAR     6   392  397   Effective with NCH weekly process date 3/7/97,
          Provider Number                                     the Medicare provider number of the HHA or Hospice
                                                              rendering Medicare covered services during
                                                              period the physician is providing care plan
                                                              oversight. The purpose of this field is to
                                                              ensure compliance with the CPO requirement that
                                                              the beneficiary must be receiving covered HHA or
                                                              Hospice services during the billing period.  There
                                                              can be only one CPO provider number per claim, and
                                                              no other services but CPO physician services are
                                                              to be reported on the claim.  This field is only
                                                              present on the non-DMERC processed carrier claim.
```

```
                                        POSITIONS
          NAME               TYPE  LENGTH BEG   END                          CONTENTS
----------------------------  ----  ------ ---------   -------------------------------------------------------------
```

NOTE: On the Version G format, this field is stored
as a redefinition of the NEAR_LINE_ORGNL_BENE_CAN_NUM
(the first 3 positions contain 'CPO', followed by
the 6-position provider number). During the
Version H conversion the data was moved to this
dedicated field.

DB2 ALIAS: CPO_PRVDR_NUM
SAS ALIAS: CPO_PROV
STANDARD ALIAS: CPO_PRVDR_NUM
TITLE ALIAS: CPO_PRVDR

SOURCE:
CWF

71. CPO Organization NPI Number CHAR   10   398   407   A placeholder field (effective with Version H)
for storing the NPI assigned to the CPO organ-
izational provider.

DB2 ALIAS: CPO_ORG_NPI_NUM
SAS ALIAS: CPO_NPI
STANDARD ALIAS: CPO_ORG_NPI_NUM
TITLE ALIAS: CPO_ORG_NPI

SOURCE:
CWF

72. Claim Blood Pints Furnished PACK   2   408   409   Number of whole pints of blood furnished to the
Quantity   beneficiary, as reported on the carrier claim
(non-DMERC).

3 DIGITS SIGNED

DB2 ALIAS: BLOOD_PT_FRNSH_QTY
SAS ALIAS: BLDFRNSH
STANDARD ALIAS: CLM_BLOOD_PT_FRNSH_QTY
TITLE ALIAS: BLOOD_PINTS_FURNISHED

EDIT-RULES:
NUMERIC

COMMENT:
Prior to Version H this field was stored in a

blood trailer. Version H eliminated the blood
trailer.

SOURCE:
CWF

73. Claim Blood Deductible   PACK   2   410 411   The quantity of blood pints applied (blood
    Pints Quantity   deductible) as reported on the carrier claim
                                                         (non-DMERC).

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                             POSITIONS
                  NAME   TYPE LENGTH BEG END   CONTENTS
        --------------------------- ---- ------ --------- --

                                                             3 DIGITS SIGNED

                                                             DB2 ALIAS: BLOOD_DDCTBL_PT
                                                             SAS ALIAS: BLD_DED
                                                             STANDARD ALIAS: CLM_BLOOD_DDCTBL_PT_QTY
                                                             TITLE ALIAS: BLOOD_PINTS_DEDUCTIBLE

                                                             EDIT-RULES:
                                                             NUMERIC

                                                             COMMENT:
                                                             Prior to Version H this field was stored in a
                                                             blood trailer. Version H eliminated the blood
                                                             trailer.

                                                             SOURCE:
                                                             CWF

74. Carrier NCH Edit Code Count NUM   2   412 413   The count of the number of edit codes
                                                         annotated to the carrier claim during
                                                         HCFA's CWFMQA process. The purpose of
                                                         this count is to indicate how many claim
                                                         edit trailers are present.

                                                             2 DIGITS UNSIGNED

                                                             DB2 ALIAS: CARR_EDIT_CD_CNT
                                                             SAS ALIAS: CEDCNT
                                                             STANDARD ALIAS: CARR_NCH_EDIT_CD_CNT

                                                             COMMENT:
                                                             Prior to Version H this field was named:
                                                                   Page 39

CLM_EDIT_CD_CNT.

SOURCE:
NCH

75. Carrier NCH Patch Code   NUM   2   414 415   Effective with Version H, the count of the
    Count   number of HCFA patch codes annotated to the
                                                       carrier claim during the Nearline maintenance
                                                       process.   The purpose of this count is to
                                                       indicate how many NCH patch trailers are
                                                       present.
                                                       NOTE: During the Version H conversion this
                                                       field was populated with data throughout
                                                       history (back to service year 1991).

                                                       2 DIGITS UNSIGNED

                                                       DB2 ALIAS: CARR_PATCH_CD_CNT
                                                       SAS ALIAS: CPATCNT
                                                       STANDARD ALIAS: CARR_NCH_PATCH_CD_I_CNT

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                       POSITIONS
             NAME   TYPE LENGTH BEG END   CONTENTS
    ---------------------------- ---- ------ --------- --

                                                       SOURCE:
                                                       NCH

76. Carrier MCO Period Count   NUM   1   416 416   Effective with Version H, the count of the
                                                       number of Managed Care Organization (MCO)
                                                       periods reported on a carrier claim.
                                                       The purpose of this count is to indicate
                                                       how many MCO period trailers are present.

                                                       NOTE: Beginning with NCH weekly process date
                                                       10/3/97 this field was populated with data.
                                                       Claims processed prior to 10/3/97 will contain
                                                       zeroes in this field.

                                                       1 DIGIT UNSIGNED

                                                       DB2 ALIAS: CARR_MCO_PRD_CNT
                                                       SAS ALIAS: CMCOCNT
                                                       STANDARD ALIAS: CARR_MCO_PRD_CNT

                                                       EDIT-RULES:

```
                                    carrier.txt
                            RANGE: 0 TO 2

                            SOURCE:
                            NCH

   77. Carrier Claim Health PlanID  NUM    1   417  417   A placeholder field (effective with Version H)
       Count                                                for storing the count of the number of Health
                                                           PlanIDs reported on the carrier claim.  The
                                                           purpose of this count is to indicate how many
                                                           Health PlanID trailers are present. NOTE:  Prior
                                                           to Version 'I' this field was named:
                                                           CARR_CLM_PAYERID_CNT.

                            1 DIGIT UNSIGNED

                            DB2 ALIAS: CARR_PLANID_CNT
                            SAS ALIAS: CPLNCNT
                            STANDARD ALIAS: CARR_CLM_HLTH_PLANID_CNT

                            EDIT-RULES:
                            RANGE: 0 TO 3

                            SOURCE:
                            NCH

   78. Carrier Claim Demonstration  NUM    1   418  418   Effective with Version H, the count of the number
       ID Count                                           of claim demonstration IDs reported on an
                                                          carrier claim.  The purpose of this count is
                                                          to indicate how many claim demonstration
                                                          trailers are present.

                            NOTE:  During the Version H conversion this field
                            was populated with data where a demo was
                            identifiable.
1                          Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                      POSITIONS
            NAME                TYPE  LENGTH BEG  END                    CONTENTS
   ----------------------------  ----  ------ ---------  -------------------------------------------------------

                            1 DIGIT UNSIGNED

                            DB2 ALIAS: CARR_DEMO_ID_CNT
                            SAS ALIAS: CDEMCNT
                            STANDARD ALIAS: CARR_CLM_DEMO_ID_CNT

                            EDIT-RULES:
                            RANGE: 0 TO 5
                                    Page 41
```

SOURCE:
NCH

79. Carrier Claim Diagnosis   NUM   1   419 419   The count of the number of diagnosis codes (both
    Code Count   principal and other) reported on an carrier
                                                          claim. The purpose of this count is to indicate
                                                          how many claim diagnosis trailers are present.

                                                          1 DIGIT UNSIGNED

                                                          DB2 ALIAS: CARR_DGNS_CD_CNT
                                                          SAS ALIAS: CDGNCNT
                                                          STANDARD ALIAS: CARR_CLM_DGNS_CD_CNT

                                                          EDIT-RULES:
                                                          RANGE: 0 TO 4

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          CLM_DGNS_CD_CNT.

                                                          SOURCE:
                                                          NCH

80. Carrier Claim Line Count   NUM   2   420 421   The count of the number of line items reported
                                                          on the carrier claim. The purpose of this count
                                                          is to indicate how many line item trailers are
                                                          present.

                                                          2 DIGITS UNSIGNED

                                                          DB2 ALIAS: CARR_CLM_LINE_CNT
                                                          SAS ALIAS: CLINECNT
                                                          STANDARD ALIAS: CARR_CLM_LINE_CNT

                                                          EDIT-RULES:
                                                          RANGE: 1 TO 13

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          CWFB_CLM_NUM_LINE_ITM_CNT.

                                                          SOURCE:
                                                          CWFB CLAIMS

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                         POSITIONS
            NAME              TYPE  LENGTH BEG   END                        CONTENTS
    ------------------------  ----  ------ ---------  ------------------------------------------------------------

     81. FILLER               CHAR     4   422   425

****  Carrier Claim Variable  GROUP   VAR             Variable portion of the carrier claim record
      Group                                           for version H of the NCH.

                                                      STANDARD ALIAS: CARR_CLM_VAR_GRP

****  NCH Edit Group          GROUP    5             The number of claim edit trailers is determined
                                                      by the claim edit code count.

                                                      OCCURS: UP TO 13 TIMES
                                                            DEPENDING ON CARR_NCH_EDIT_CD_CNT

                                                      STANDARD ALIAS: NCH_EDIT_GRP

     82. NCH Edit Trailer Indicator  CHAR  1         Effective with Version H, the code indicating
         Code                                         the presence of an NCH edit trailer.

                                                      NOTE:  During the Version H conversion this field
                                                      was populated throughout history (back to service
                                                      year 1991).

                                                      DB2 ALIAS: EDIT_TRLR_IND_CD
                                                      SAS ALIAS: EDITIND
                                                      STANDARD ALIAS: NCH_EDIT_TRLR_IND_CD

                                                      CODES:
                                                      E = Edit code trailer present

                                                      SOURCE:
                                                      NCH QA Process

     83. NCH Edit Code         CHAR     4             The code annotated to the claim indicating
                                                      the CWFMQA editing results so users will
                                                      be aware of data deficiencies.

                                                      NOTE:  Prior to Version H only the highest
                                                      priority code was stored.  Beginning 11/98
                                                      up to 13 edit codes may be present.

                                                      COMMON ALIAS: QA_ERROR_CODE
                                                      DB2 ALIAS: NCH_EDIT_CD
                                                      SAS ALIAS: EDIT_CD
                                                      STANDARD ALIAS: NCH_EDIT_CD
```

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                                  TITLE ALIAS: QA_ERROR_CD

                                  CODES:
                                    REFER TO: NCH_EDIT_TB
                                              IN THE CODES APPENDIX

                                  SOURCE:
                                  NCH QA EDIT PROCESS
1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                          POSITIONS
              NAME   TYPE LENGTH BEG   END   CONTENTS
    --------------------------   ---- ------ ---------   --

 **** NCH Patch Group   GROUP   11   OCCURS: UP TO 30 TIMES
                                                              DEPENDING ON CARR_NCH_PATCH_CD_I_CNT

                                                         STANDARD ALIAS: NCH_PATCH_GRP

   84. NCH Patch Trailer Indicator CHAR   1   Effective with Version H, the code indicating
       Code   the presence of an NCH patch trailer.

                                                         NOTE: During the Version H conversion this field
                                                         was populated throughout history (back to service
                                                         year 1991).

                                                         DB2 ALIAS: PATCH_TRLR_IND_CD
                                                         SAS ALIAS: PATCHIND
                                                         STANDARD ALIAS: NCH_PATCH_TRLR_IND_CD

                                                         CODES:
                                                         P = Patch code trailer present

                                                         SOURCE:
                                                         NCH

   85. NCH Patch Code   CHAR   2   Effective with Version H, the code annotated
                                                         to the claim indicating a patch was applied
                                                         to the record during an NCH Nearline record
                                                         conversion and/or during current processing.

                                                         NOTE: Prior to Version H this field was located
                                                         in the third and fourth occurrence of the
                                                         CLM_EDIT_CD.

                                                         DB2 ALIAS: NCH_PATCH_CD
                                                         SAS ALIAS: PATCHCD
                                                         STANDARD ALIAS: NCH_PATCH_CD

TITLE ALIAS: NCH_PATCH

CODES:
  REFER TO: NCH_PATCH_TB
            IN THE CODES APPENDIX
SOURCE:
NCH

	NAME	TYPE	LENGTH	CONTENTS
86.	NCH Patch Applied Date	NUM	8	Effective with Version H, the date the NCH patch was applied to the claim.

8 DIGITS UNSIGNED

DB2 ALIAS: NCH_PATCH_APPLY_DT
SAS ALIAS: PATCHDT
STANDARD ALIAS: NCH_PATCH_APPLY_DT
TITLE ALIAS: NCH_PATCH_DT

EDIT-RULES:
YYYYMMDD

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | | POSITIONS | |
NAME	TYPE	LENGTH	BEG END	CONTENTS

SOURCE:
NCH

| **** | MCO Period Group | GROUP | 37 | The number of managed care organization (MCO) period data trailers present is determined by the claim MCO period trailer count. This field reflects the two most current MCO periods in the CWF beneficiary history record. It may have no connection to the services on the claim. |

OCCURS: UP TO 2 TIMES
        DEPENDING ON CARR_MCO_PRD_CNT

STANDARD ALIAS: MCO_PRD_GRP

| 87. | NCH MCO Trailer Indicator Code | CHAR | 1 | Effective with Version H, the code indicating the presence of a Managed Care Organization (MCO) trailer. |

NOTE: Beginning with NCH weekly process date 10/3/97 this field was populated with data.

```
                              carrier.txt
                   Claims processed prior to 10/3/97 will contain
                   spaces in this field.

                   COBOL ALIAS: MCO_IND
                   DB2 ALIAS: MCO_TRLR_IND_CD
                   SAS ALIAS: MCOIND
                   STANDARD ALIAS: NCH_MCO_TRLR_IND_CD
                   TITLE ALIAS: MCO_INDICATOR

                   CODES:
                   M = MCO trailer present

                   SOURCE:
                   NCH QA Process

  88. MCO Contract Number        CHAR    5       Effective with Version H, this field represents
                                                 the plan contract number of the Managed Care
                                                 Organization (MCO).

                                                 NOTE:  Beginning with NCH weekly process date
                                                 10/3/97 this field was populated with data.
                                                 Claims processed prior to 10/3/97 will contain
                                                 spaces in this field.

                                                 DB2 ALIAS: MCO_CNTRCT_NUM
                                                 SAS ALIAS: MCONUM
                                                 STANDARD ALIAS: MCO_CNTRCT_NUM
                                                 TITLE ALIAS: MCO_NUM

                                                 SOURCE:
                                                 CWF
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                       POSITIONS
              NAME              TYPE  LENGTH BEG   END                        CONTENTS
   ----------------------------  ----  ------ ---------   ------------------------------------------------------------

  89. MCO Option Code            CHAR    1       Effective with Version H, the code indicating
                                                 Managed Care Organization (MCO) lock-in
                                                 enrollment status of the beneficiary.

                                                 NOTE:  Beginning with NCH weekly process date
                                                 10/3/97 this field was populated with data.
                                                 Claims processed prior to 10/3/97 will contain
                                                 spaces in this field.

                                                 DB2 ALIAS: MCO_OPTN_CD
```

```
                              carrier.txt
                              SAS ALIAS: MCOOPTN
                              STANDARD ALIAS: MCO_OPTN_CD
                              TITLE ALIAS: MCO_OPTION_CD

                              CODES:
                              *****For lock-in beneficiaries****
                              A = HCFA to process all provider bills
                              B = MCO to process only in-plan
                              C = MCO to process all Part A and Part B bills

                              ***** For non-lock-in beneficiaries*****
                              1 = HCFA to process all provider bills
                              2 = MCO to process only in-plan Part A and
                                  Part B bills

                              SOURCE:
                              CWF
```

90. MCO Period Effective Date   NUM   8   Effective with Version H, the date the bene-
                                                 ficiary's enrollment in the Managed Care
                                                 Organization (MCO) became effective.

                                                 NOTE: Beginning with NCH weekly process date
                                                 10/3/97 this field was populated with data.
                                                 Claims processed prior to 10/3/97 will contain
                                                 zeroes in this field.

                                                 8 DIGITS UNSIGNED

                                                 DB2 ALIAS: MCO_PRD_EFCTV_DT
                                                 SAS ALIAS: MCOEFFDT
                                                 STANDARD ALIAS: MCO_PRD_EFCTV_DT
                                                 TITLE ALIAS: MCO_PERIOD_EFF_DT

                                                 EDIT-RULES:
                                                 YYYYMMDD

                                                 SOURCE:
                                                 CWF

91. MCO Period Termination Date NUM   8   Effective with Version H, the date the bene-
                                                 ficiary's enrollment in the Managed Care
                                                 Organization (MCO) was terminated.

                              POSITIONS
          NAME   TYPE LENGTH BEG END   CONTENTS

```
--------------------------  ----  ------ --------   ------------------------------------------------------------
```

                                                    NOTE: Beginning with NCH weekly process date
                                                    10/3/97 this field was populated with data.
                                                    Claims processed prior to 10/3/97 will contain
                                                    zeroes in this field.

                                                    8 DIGITS UNSIGNED

                                                    DB2 ALIAS: MCO_PRD_TRMNTN_DT
                                                    SAS ALIAS: MCOTRMDT
                                                    STANDARD ALIAS: MCO_PRD_TRMNTN_DT
                                                    TITLE ALIAS: MCO_PERIOD_TERM_DT

                                                    EDIT-RULES:
                                                    YYYYMMDD

                                                    SOURCE:
                                                    CWF

  92. MCO Health PLANID Number   CHAR   14   A placeholder field (effective with Version H)
                                                    for storing the Health PlanID associated with
                                                    the Managed Care Organization (MCO). Prior to
                                                    Version 'I' this field was named:
                                                    MCO_PAYERID_NUM.

                                                    DB2 ALIAS: MCO_PLANID_NUM
                                                    SAS ALIAS: MCOPLNID
                                                    STANDARD ALIAS: MCO_HLTH_PLANID_NUM
                                                    TITLE ALIAS: MCO_PLANID

                                                    COMMENT:
                                                    Prior to Version I this field was named:
                                                    MCO_PAYERID_NUM.

                                                    SOURCE:
                                                    CWF

 **** Claim Health PlanID Group   GROUP   16   The number of Health PlanID data trailers is determined
                                                    by the claim Health PlanID trailer count. Prior
                                                    to Version 'I' this field was named:
                                                    CLM_PAYERID_GRP.

                                                    OCCURS: UP TO 3 TIMES
                                                            DEPENDING ON CARR_CLM_HLTH_PLANID_CNT

                                                    STANDARD ALIAS: CLM_HLTH_PLANID_GRP

                                                    Page 48

```
    93. NCH Health PlanID Trailer    CHAR      1              A placeholder field (effective with Version H)
        Indicator Code                                        for storing the code that indicates the presence
                                                              of a Health PlanID trailer.  NOTE: Prior to
                                                              Version 'I' this field was named:
                                                              NCH_PAYERID_TRLR_IND_CD.

                                                              DB2 ALIAS: PLANID_TRLR_CD
                                                              SAS ALIAS: PLANIDIN
                                                              STANDARD ALIAS: NCH_HLTH_PLANID_TRLR_IND_CD
1                          Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                            POSITIONS
                  NAME                TYPE  LENGTH BEG  END                        CONTENTS
        ---------------------------  ----  ------ ---------  ----------------------------------------------------------

                                                              CODES:
                                                              I = Health PlanID trailer present

                                                              COMMENT:
                                                              Prior to Version I this field was named:
                                                              NCH_PAYERID_TRLR_IND_CD.

                                                              SOURCE:
                                                              NCH

    94. Claim Health PlanID Code     CHAR      1              A placeholder field (effective with Version H)
                                                              for storing the code identifying the type of
                                                              Health PlanID.  Prior to Version 'I' this field
                                                              was named: CLM_PAYERID-CD

                                                              DB2 ALIAS: CLM_PLANID_CD
                                                              SAS ALIAS: PLANIDCD
                                                              STANDARD ALIAS: CLM_HLTH_PLANID_CD
                                                              TITLE ALIAS: PLANID_TYPE

                                                              CODES:
                                                              1 = Medicare Secondary Payer
                                                              2 = Medicaid
                                                              3 = Medigap
                                                              4 = Supplemental Insurer
                                                              5 = Managed Care Organization

                                                              COMMENT:
                                                              Prior to Version I this field was named:
                                                              CLM_PAYERID_CD.

                                                              SOURCE:
                                                              CWF
```

```
    95. Claim Health PlanID Number   CHAR     14                A placeholder field (effective with Version H)
                                                                for storing the Health PlanID number.  Prior
                                                                to Version 'I' this field was named:
                                                                CLM_PAYERID_NUM.

                                                                DB2 ALIAS: CLM_PLANID_NUM
                                                                SAS ALIAS: PLANID
                                                                STANDARD ALIAS: CLM_HLTH_PLANID_NUM
                                                                TITLE ALIAS: PLANID

                                                                COMMENT:
                                                                Prior to Version I this field was named:
                                                                CLM_PAYERID_NUM.

                                                                SOURCE:
                                                                CWF

 ****  Claim Demonstration         GROUP    18                The number of demonstration identification
       Identification Group                                   trailers present is determined by the claim
                                                              demonstration identification trailer count.
1                          Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                           POSITIONS
               NAME                TYPE  LENGTH BEG  END                      CONTENTS
       ----------------------------  ----  ------ ---------  ------------------------------------------------------

                                                                OCCURS: UP TO 5 TIMES
                                                                       DEPENDING ON CARR_CLM_DEMO_ID_CNT

                                                                STANDARD ALIAS: CLM_DEMO_ID_GRP

    96. NCH Demonstration Trailer    CHAR     1                 Effective with Version H, the code indicating
        Indicator Code                                          the presence of a demo trailer.

                                                                NOTE:  During the Version H conversion this field
                                                                was populated throughout history (back to service
                                                                year 1991).

                                                                COBOL ALIAS: DEMO_IND
                                                                DB2 ALIAS: DEMO_TRLR_IND_CD
                                                                SAS ALIAS: DEMOIND
                                                                STANDARD ALIAS: NCH_DEMO_TRLR_IND_CD
                                                                TITLE ALIAS: DEMO_INDICATOR

                                                                CODES:
                                                                D = Demo trailer present
```

SOURCE:
NCH

```
97. Claim Demonstration          CHAR      2              Effective with Version H, the number assigned
    Identification Number                                 to identify a demo.  This field is also used to
                                                          denote special processing (a.k.a. Special Processing
                                                          Number, SPN).

                                                          NOTE: Prior to Version H, Demo ID was stored in the
                                                          redefined Claim Edit Group, 4th occurrence, positions
                                                          3 and 4.   During the H conversion, this field was
                                                          populated with data throughout history (as appro-
                                                          priate either by moving ID on Version G or by
                                                          deriving from specific demo criteria).

                                                          01 = Nursing Home Case-Mix and Quality: NHCMQ
                                                               (RUGS) Demo -- testing PPS for SNFs in 6
                                                               states, using a case-mix classification
                                                               system based on resident characteristics and
                                                               actual resources used. The claims carry a
                                                               RUGS indicator and one or more revenue center
                                                               codes in the 9,000 series.

                                                          NOTE1: Effective for SNF claims with NCH weekly
                                                          process date after 2/8/96 (and service date after
                                                          12/31/95) -- beginning 4/97, Demo ID '01' was
                                                          derived in NCH based on presence of RUGS phase #
                                                          '2','3' or '4' on incoming claim; since 7/97, CWF
                                                          has been adding ID to claim.
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                       POSITIONS
            NAME                   TYPE  LENGTH BEG   END                          CONTENTS
  ----------------------------     ----  ------ ---------    -------------------------------------------------------------
                                                          NOTE2:  During the Version H conversion, Demo ID
                                                          '01' was populated back to NCH weekly process date
                                                          2/9/96 based on the RUGS phase indicator (stored
                                                          in Claim Edit Group, 3rd occurrence, 4th position,
                                                          in Version G).

                                                          02 = National HHA Prospective Payment Demo --
                                                               testing PPS for HHAs in 5 states, using two
                                                               alternate methods of paying HHAs: per visit
                                                               by type of HHA visit and per episode of HH
                                                               care.

                                                          NOTE1:  Effective for HHA claims with NCH weekly
```

process date after 5/31/95 -- beginning 4/97,
Demo ID '02' was derived in NCH based on HCFA/
CHPP-supplied listing of provider # and start/
stop dates of participants.

NOTE2: During the Version H conversion, Demo ID
'02' was populated back to NCH weekly process
date 6/95 based on the CHPP criteria.

03 = Telemedicine Demo -- testing covering tradi-
       tionally noncovered physician services for
       medical consultation furnished via two-way, inter-
       active video systems (i.e. teleconsultation)
       in 4 states. The claims contain line items
       with 'QQ' HCPCS code.

NOTE1: Effective for physician/supplier (nonDMERC)
claims with NCH weekly process date after 12/31/96
(and service date after 9/30/96) -- since 7/97,
CWF has been adding Demo ID '03' to claim.

NOTE2: During Version H conversion, Demo ID '03'
was populated back to NCH weekly process date 1/97
based on the presence of 'QQ' HCPCS on one or more
line items.

04 = United Mine Workers of America (UMWA) Managed
       Care Demo -- testing risk sharing for Part A
       services, paying special capitation rates for
       all UMWA beneficiaries residing in 13 desig-
       nated counties in 3 states.   Under the demo,
       UMWA will waive the 3-day qualifying hospital
       stay for a SNF admission.   The claims contain
       TOB '18X','21X','28X' and '51X'; condition
       code = W0; claim MCO paid switch = not '0';
       and MCO contract # = '90091'.

NOTE: Initially scheduled to be implemented for
all SNF claims for admission or services on
1/1/97 or later, CWF did not transmit any Demo
ID '04' annotated claims until on or about 2/98.

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | | POSITIONS | |
NAME	TYPE	LENGTH	BEG END	CONTENTS

05 = Medicare Choices (MCO encounter data) demo --

carrier.txt
testing expanding the type of Managed Care
plans available and different payment methods
at 16 MCOs in 9 states. The claims contain
one of the specific MCO Plan Contract #
assigned to the Choices Demo site.

NOTE1: Effective for all claim types with NCH
weekly process date after 7/31/97 -- CWF adds
Demo ID '05' to claim based on the presences of
the MCO Plan Contract #.

NOTE2: During the Version H conversion, Demo ID
'05' was populated back to NCH weekly process
date 8/97 based on the presence of the Choices
indicator (stored as an alpha character cross-
walked from MCO plan contract # in the Claim
Edit Group, 4th occurrence, 2nd position, in
Version 'G').

06 = Coronary Artery Bypass Graft (CABG) Demo --
testing bundled payment (all-inclusive global
pricing) for hospital + physician services
related to CABG surgery in 7 hospitals in 7
states. The inpatient claims contain a DRG
'106' or '107'.

NOTE1: Effective for Inpatient claims and
physician/supplier claims with Claim Edit Date
no earlier than 6/1/91 (not all CABG sites
started at the same time) -- on 5/1/97, CWF
started transmitting Demo ID '06' on the claim.
The FI adds the ID to the claim based on the
presence of DRG '106' or '107' from specific
providers for specified time periods; the
carrier adds the ID to the claim based on
receiving 'Daily Census List' from parti-
cipating hospitals. Demo ID '06' will end
once Demo ID '07' is implemented.

NOTE2: During the Version H conversion, any
claims where Medicare is the primary payer
that were not already identified as Demo ID
'06' (stored in the redefined Claim Edit
Group, 4th occurrence, positions 3 and 4,
Version G) were annotated based on the follow-
ing criteria: Inpatient - presence of DRG '106'
or '107' and a provider number=220897, 150897,
380897,450897,110082,230156 or 360085 for

specified service dates; noninstitutional -
presence of HCPCS modifier (initial and/or
second) = 'Q2' and a carrier number =00700/31143
00630,01380,00900,01040/00511,00710,00623, or
13630 for specified service dates.

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

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                                        POSITIONS
        NAME                 TYPE   LENGTH BEG   END                              CONTENTS
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```

                                                    07 = Participating Centers of Excellence (PCOE)
                                                         Demo -- testing a negotiated all-inclusive
                                                         pricing arrangement (bundled rates) for high-
                                                         cost acute care cardiovascular and orthopedic
                                                         procedures performed in 60-100 premier facili-
                                                         ties in the Chicago and San Francisco Regions
                                                         or by current CABG providers. The inpatient
                                                         claims will contain a DRG '104','105','106',
                                                         '107','112','124','125','209',or '471'; the
                                                         related physician/supplier claims will contain
                                                         the claim payment denial reason code = 'D'.

                                                    NOTE: The demo is on HOLD. The FI and carrier will
                                                    add Demo ID '07' to claim.

                                                    08 = Provider Partnership Demo -- testing per-case
                                                         payment approaches for acute inpatient
                                                         hospitalizations, making a lump-sum payment
                                                         (combining the normal Part A PPS payment with
                                                         the Part B allowed charges into a single fee
                                                         schedule) to a Physician/Hospital Organization
                                                         for all Part A and Part B services associated
                                                         with a hospital admission. From 3 to 6 hospitals
                                                         in the Northeast and Mid-Atlantic regions may
                                                         participate in the demo.

                                                    NOTE: The demo is on HOLD. The FI and carrier will
                                                    add Demo ID '08' to claim.

                                                    15 = ESRD Managed Care (MCO encounter data) --
                                                         testing open enrollment of ESRD beneficiaries
                                                         and capitation rates adjusted for patient
                                                         treatment needs at 3 MCOs in 3 States. The
                                                         claims contain one of the specific MCO Plan
                                                         Contract # assigned to the ESRD demo site.

                                                    NOTE: Effective 10/1/97 (but not actually imple-

mented at a site until 1/1/98) for all claim
types -- the FI and carrier add Demo ID '15' to
claim based on the presence of the MCO plan
contract #.

```
30 = Lung Volume Reduction Surgery (LVRS) or
     National Emphysema Treatment Trial (NETT)
     Clinical Study -- evaluating the effective-
     ness of LVRS and maximum medical therapy (in-
     cluding pulmonary rehab) for Medicare bene-
     ficiaries in last stages of emphysema at 18
     hospitals nationally, in collaboration with
     NIH.
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                          POSITIONS
        NAME              TYPE  LENGTH BEG   END                         CONTENTS
---------------------     ----  ------ ---------     ------------------------------------------------------------
```

NOTE: Effective for all claim types (except DMERC)
with NCH weekly process date after 2/27/98 (and
service date after 10/31/97) -- the FI adds Demo ID
'30' based on the presence of a condition code = EY;
the participating physician (not the carrier) adds
ID to the noninstitutional claim. DUE TO THE SEN-
SITIVE NATURE OF THIS CLINICAL TRIAL AND UNDER THE
TERMS OF THE INTERAGENCY AGREEMENT WITH NIH, THESE
CLAIMS ARE PROCESSED BY CWF AND TRANSMITTED TO
HCFA BUT NOT STORED IN THE NEARLINE FILE (access
is restricted to study evaluators only).

```
31 = VA Pricing Special Processing (SPN) -- not really
     a demo but special request from VA due to
     court settlement; not Medicare services but
     VA inpatient and physician services submitted
     to FI 00400 and Carrier 00900 to obtain
     Medicare pricing -- CWF WILL PROCESS VA
     CLAIMS ANNOTATED WITH DEMO ID '31', BUT WILL
     NOT TRANSMIT TO HCFA (not in Nearline File).
```

```
37 = Medicare Coordinated Care Demonstration -- to test
     whether coordinated care services furnished to
     certain beneficiaries improve outcomes of care
     and reduce Medicare expenditures under Part A and
     Part B.  There will be at least 9 Coordinated
     Care Entities (CCEs).  The selected entities will
     be assigned a provider number specifically for the
     demonstration services.
```

NOTE: The demo is on HOLD. The FI and carrier will
add Demo ID '37' to claim.

38 = Physician Encounter Claims - the purpose of this
      demo id is to identify the physician encounter
      claims being processed at the HCFA Data Center (HDC).
      This number will help EDS in making the claim go
      through the appropriate processing logic, which
      differs from that for fee-for-service. **NOT
      IN NCH -- AVAILABLE IN NMUD.**

NOTE: Effective October, 2000. Demo ids will not be
assigned to Inpatient and Outpatient encounter claims.

39 = Centralized Billing of Flu and PPV Claims -- The
      purpose of this demo is to facilitate the processing
      carrier, Trailblazers, paying flu and PPV claims
      based on payment localities. Providers will be
      giving the shots throughout the country and trans-
      mitting the claims to Trailblazers for processing.

NOTE: Effective October, 2000 for carrier claims.

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
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					DB2 ALIAS: CLM_DEMO_ID_NUM
					SAS ALIAS: DEMONUM
					STANDARD ALIAS: CLM_DEMO_ID_NUM
					TITLE ALIAS: DEMO_ID
					SOURCE:
					CWF
98. Claim Demonstration Information Text	CHAR	15			Effective with Version H, the text field that contains related demo information. For example, a claim involving a CHOICES demo id '05' would contain the MCO plan contract number in the first five positions of this text field.
					NOTE: During the Version H conversion this field was populated with data throughout history.

carrier.txt

DB2 ALIAS: CLM_DEMO_INFO_TXT
SAS ALIAS: DEMOTXT
STANDARD ALIAS: CLM_DEMO_INFO_TXT
TITLE ALIAS: DEMO_INFO

DERIVATION:
DERIVATION RULES:
Demo ID = 01 (RUGS) -- the text field will contain
a 2, 3 or 4 to denote the RUGS phase. If RUGS phase
is blank or not one of the above the text field
will reflect 'INVALID'. NOTE: In Version 'G', RUGS
phase was stored in redefined Claim Edit Group,
3rd occurrence, 4th position.

Demo ID = 02 (Home Health demo) -- the text field
will contain PROV#. When demo number not equal to
02 then text will reflect 'INVALID'.

Demo ID = 03 (Telemedicine demo) -- text field will
contain the HCPCS code. If the required HCPCS is
not shown then the text field will reflect
'INVALID'.

Demo ID = 04 (UMWA) -- text field will contain
W0 denoting that condition code W0 was present.
If condition code W0 not present then the text
field will reflect 'INVALID'.

Demo ID = 05 (CHOICES) -- the text field will con-
tain the CHOICES plan number, if both of the follow-
ing conditions are met: (1) CHOICES plan number
present and PPS or Inpatient claim shows that 1st
3 positions of provider number as '210' and the
admission date is within HMO effective/termination
date; or non-PPS claim and the from date is within

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

HMO effective/termination date and (2) CHOICES
plan number matches the HMO plan number. If
either condition is not met the text field will
reflect 'INVALID CHOICES PLAN NUMBER'. When
CHOICES plan number not present, text will re-
flect 'INVALID'.

NOTE: In Version 'G', a valid CHOICES plan ID is
stored as alpha character in redefined Claim
Edit Group, 4th occurrence, 2nd position. If
invalid, CHOICES indicator 'ZZ' displayed.

Demo ID = 15 (ESRD Managed Care) -- text field
will contain the ESRD/MCO plan number. If ESRD/
MCO plan number not present the field will
reflect 'INVALID'.

Demo ID = 38 (Physician Encounter Claims) --
text field will contain the MCO plan number.
When MCO plan number not present the field will
reflect 'INVALID'.

SOURCE:
CWF

****	Carrier Claim Diagnosis Group	GROUP	7	OCCURS: UP TO 4 TIMES DEPENDING ON CARR_CLM_DGNS_CD_CNT

STANDARD ALIAS: CARR_CLM_DGNS_GRP

99.	NCH Diagnosis Trailer Indicator Code	CHAR	1	Effective with Version H, the code indicating the presence of a diagnosis trailer.

NOTE: During the Version H conversion this field
was populated throughout history (back to service
year 1991).

DB2 ALIAS: DGNS_TRLR_IND_CD
SAS ALIAS: DGNSIND
STANDARD ALIAS: NCH_DGNS_TRLR_IND_CD

CODES:
Y = Diagnosis code trailer present

SOURCE:
NCH

100.	Claim Diagnosis Code	CHAR	5	The ICD-9-CM based code identifying the beneficiary's principal or other diagnosis (including E code).

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

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                                     POSITIONS
            NAME              TYPE  LENGTH BEG  END                        CONTENTS
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```

                                                      NOTE:
                                                      Prior to Version H, the principal diagnosis
                                                      code was not stored with the 'OTHER' diagnosis
                                                      codes. During the Version H conversion the
                                                      CLM_PRNCPAL_DGNS_CD was added as the first
                                                      occurrence.

                                                      DB2 ALIAS: CLM_DGNS_CD
                                                      SAS ALIAS: DGNS_CD
                                                      STANDARD ALIAS: CLM_DGNS_CD
                                                      TITLE ALIAS: DIAGNOSIS

                                                      EDIT-RULES:
                                                      ICD-9-CM

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      CLM_OTHR_DGNS_CD.

101. FILLER   CHAR   1

**** Carrier Line Item Group GROUP   294   The line item trailer group may occur
                                                      multiple times in one carrier claim. Up to 13
                                                      occurrences may be present.

                                                      OCCURS: UP TO 13 TIMES
                                                              DEPENDING ON CARR_CLM_LINE_CNT

                                                      STANDARD ALIAS: CARR_LINE_GRP

102. NCH Line Item Trailer   CHAR   1   Effective with Version H, the code indicating
     Indicator Code   the presence of a line item trailer on the non-
                                                      institutional claim.

                                                      NOTE: During the Version H conversion this field
                                                      was populated throughout history (back to service
                                                      year 1991).

                                                      DB2 ALIAS: LINE_TRLR_IND_CD
                                                      SAS ALIAS: LINEIND
                                                      STANDARD ALIAS: NCH_LINE_TRLR_IND_CD

                                                      CODES:
                                                      L = Line Item trailer present

Blank = No trailer present

SOURCE:
NCH

103. Carrier Line Performing PIN   CHAR   10   The profiling identification number (PIN) of the
     Number   physician\supplier who performed the service
                                                          for this line item on the carrier claim
                                                          (non-DMERC).

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
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COMMON ALIAS: PHYSICIAN/SUPPLIER_PROVIDER_NUM
DB2 ALIAS: LINE_PRFRMG_PIN
SAS ALIAS: PRF_PRFL
STANDARD ALIAS: CARR_LINE_PRFRMG_PIN_NUM
TITLE ALIAS: PRFRMG_PIN

COMMENT:
Prior to Version H this field was named:
CWFB_PRFRMG_PRVDR_PRFLG_NUM.

SOURCE:
CWF

104. Carrier Line Performing   CHAR   6   The unique physician identification number
     UPIN Number   (UPIN) of the physician who performed the
                                                          service for this line item on the carrier
                                                          claim (non-DMERC).

                                                          DB2 ALIAS: LINE_PRFRMG_UPIN
                                                          SAS ALIAS: PRF_UPIN
                                                          STANDARD ALIAS: CARR_LINE_PRFRMG_UPIN_NUM
                                                          TITLE ALIAS: PRFRMG_UPIN

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          CWFB_PRFRMG_PRVDR_UPIN_NUM.

                                                          SOURCE:
                                                          CWF

105. Carrier Line Performing NPI   CHAR   10   A placeholder field (effective with Version H)
     Number   for storing the NPI assigned to the performing

```
                    carrier.txt
                  provider.

                  COMMON ALIAS: PERFORMING_PROVIDER_NPI
                  DB2 ALIAS: LINE_PRFRMG_NPI
                  SAS ALIAS: PRFNPI
                  STANDARD ALIAS: CARR_LINE_PRFRMG_NPI_NUM
                  TITLE ALIAS: PRFRMG_NPI

                  SOURCE:
                  CWF

106. Carrier Line Performing      CHAR    10        A placeholder field (effective with Version H)
     Group NPI Number                               for storing the NPI assigned to a group practice,
                                                    where the performing physician is part of that
                                                    group.  If the physician is not part of a group,
                                                    this field will be blank.

                                                    DB2 ALIAS: PRFRMG_GRP_NPI
                                                    SAS ALIAS: PRGRPNPI
                                                    STANDARD ALIAS: CARR_LINE_PRFRMG_GRP_NPI_NUM
                                                    TITLE ALIAS: PRFRMG_GROUP_NPI
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

```
                                    POSITIONS
              NAME              TYPE LENGTH BEG  END                        CONTENTS
     ----------------------------  ----  ------ ---------  ------------------------------------------------------------
                                                    SOURCE:
                                                    CWF

107. Carrier Line Provider Type   CHAR     1        Code identifying the type of provider
     Code                                           furnishing the service for this line item
                                                    on the carrier claim (non-DMERC).

                                                    DB2 ALIAS: LINE_PRVDR_TYPE_CD
                                                    SAS ALIAS: PRV_TYPE
                                                    STANDARD ALIAS: CARR_LINE_PRVDR_TYPE_CD
                                                    TITLE ALIAS: PRVDR_TYPE

                                                    CODES:
                                                      REFER TO: CARR_LINE_PRVDR_TYPE_TB
                                                               IN THE CODES APPENDIX

                                                    COMMENT:
                                                    Prior to Version H this field was named:
                                                    CWFB_PRVDR_TYPE_CD.

                                                    SOURCE:
```

CWF

108. Line Provider Tax Number   CHAR   10   Social security number or employee
                                                         identification number of physician/supplier
                                                         used to identify to whom payment is made for
                                                         the line item service on the noninstitutional
                                                         claim.

                                                         DB2 ALIAS: LINE_PRVDR_TAX_NUM
                                                         SAS ALIAS: TAX_NUM
                                                         STANDARD ALIAS: LINE_PRVDR_TAX_NUM
                                                         TITLE ALIAS: PRVDR_TAX_NUM

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         CWFB_PRVDR_TAX_NUM.

                                                         SOURCE:
                                                         CWF

109. Line NCH Provider State   CHAR   2   Effective with Version H, the two position
     Code   SSA state code where provider facility is
                                                         located.

                                                         NOTE: During the Version H conversion this field
                                                         was populated with data throughout history (back
                                                         to service year 1991).

                                                         DB2 ALIAS: LINE_PRVDR_STATE
                                                         SAS ALIAS: PRVSTATE
                                                         STANDARD ALIAS: LINE_NCH_PRVDR_STATE_CD
                                                         TITLE ALIAS: PRVDR_STATE

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                                             POSITIONS
              NAME   TYPE   LENGTH BEG   END   CONTENTS
     ---------------------------- ----   ------ ---------   ---

                                                         DERIVATION:
                                                         DERIVED FROM:
                                                           CARR_LINE_PRFRMG_PRVDR_ZIP_CD

                                                         DERIVATION RULES:

                                                         Use the first three positions of the provider
                                                         zip code to derive the LINE_NCH_PRVDR_STATE_CD
                                                         from a crosswalk file.   Where a match is not

achieved this field will be blank.

CODES:
  REFER TO: GEO_SSA_STATE_TB

SOURCE:
NCH

110. Carrier Line Performing   CHAR   9   The ZIP code of the physician/supplier who
     Provider ZIP Code   performed the Part B service for this line
                                                  item on the carrier claim (non-DMERC).

                                                  DB2 ALIAS: LINE_PRVDR_ZIP_CD
                                                  SAS ALIAS: PROVZIP
                                                  STANDARD ALIAS: CARR_LINE_PRFRMG_PRVDR_ZIP_CD
                                                  TITLE ALIAS: PRVDR_ZIP_CD

                                                  COMMENT:
                                                  Prior to Version H this field was named:
                                                  CWFB_PRFRMG_PRVDR_ZIP_CD and the field size
                                                  was S9(9).

                                                  SOURCE:
                                                  CWF

111. Line HCFA Provider   CHAR   2   HCFA specialty code used for pricing the
     Specialty Code   line item service on the noninstitutional
                                                  claim.

                                                  DB2 ALIAS: HCFA_SPCLTY_CD
                                                  SAS ALIAS: HCFASPCL
                                                  STANDARD ALIAS: LINE_HCFA_PRVDR_SPCLTY_CD
                                                  TITLE ALIAS: HCFA_PRVDR_SPCLTY

                                                  CODES:
                                                    REFER TO: HCFA_PRVDR_SPCLTY_TB
                                                              IN THE CODES APPENDIX

                                                  COMMENT:
                                                  Prior to Version H this field was named:
                                                  CWFB_HCFA_PRVDR_SPCLTY_CD.

                                                  SOURCE:
                                                  CWF

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                                    POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS

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112. Carrier Line Provider        CHAR    2            The carrier's specialty code for the provider
     Specialty Code                                    (usually different from HCFA's) used for
                                                       pricing the service for this line item on
                                                       the carrier claim (non-DMERC).

                                                       DB2 ALIAS: PRVDR_SPCLTY_CD
                                                       SAS ALIAS: CARRSPCL
                                                       STANDARD ALIAS: CARR_LINE_PRVDR_SPCLTY_CD
                                                       TITLE ALIAS: CARR_PRVDR_SPCLTY

                                                       EDIT-RULES:
                                                       CARRIER INFORMATION FILE

                                                       COMMENT:
                                                       Prior to Version H this field was named:
                                                       CWFB_CARR_PRVDR_SPCLTY_CD.

                                                       SOURCE:
                                                       CWF

113. Line Provider Participating  CHAR    1            Code indicating whether or not a provider is
     Indicator Code                                    participating or accepting assignment for this
                                                       line item service on the noninstitutional claim.

                                                       DB2 ALIAS: PRVDR_PRTCPTG_CD
                                                       SAS ALIAS: PRTCPTG
                                                       STANDARD ALIAS: LINE_PRVDR_PRTCPTG_IND_CD
                                                       TITLE ALIAS: PRVDR_PRTCPTG_IND

                                                       CODES:
                                                         REFER TO: LINE_PRVDR_PRTCPTG_IND_TB
                                                                   IN THE CODES APPENDIX

                                                       COMMENT:
                                                       Prior to Version H this field was named:
                                                       CWFB_PRVDR_PRTCPTG_IND_CD.

                                                       SOURCE:
                                                       CWF

114. Carrier Line Reduced         CHAR    1            Effective 1/92, the code on the carrier (non-DMERC)
     Payment Physician Assistant                       line item that identifies claims that have been
     Code                                              paid a reduced fee schedule amount (65%, 75% or 85%)
                                                       because a physician's assistant performed the
                                                       services.
```

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                                      POSITIONS
             NAME              TYPE  LENGTH BEG  END                            CONTENTS
----------------------------- ---- ------ ---------   -------------------------------------------------------------
```

                                                      COMMON ALIAS: PA_65/75/85%_FEE
                                                      DB2 ALIAS: PHYSN_ASTNT_CD
                                                      SAS ALIAS: ASTNT_CD
                                                      STANDARD ALIAS: CARR_LINE_RDCD_PHYSN_ASTNT_CD
                                                      TITLE ALIAS: PHYSN_ASTNT_CD

                                                      CODES:
                                                        REFER TO: CARR_LINE_RDCD_PHYSN_ASTNT_TB
                                                                     IN THE CODES APPENDIX

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      CWFB_RDCD_PMT_PHYSN_ASTNT_CD.

                                                      SOURCE:
                                                      CWF

115. Line Service Count   PACK   2   The count of the total number of services
                                                      processed for the line item on the non-institutional
                                                      claim.

                                                      3 DIGITS SIGNED

                                                      DB2 ALIAS: SRVC_CNT
                                                      SAS ALIAS: SRVC_CNT
                                                      STANDARD ALIAS: LINE_SRVC_CNT

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      CWFB_SRVC_CNT.

                                                      SOURCE:
                                                      CWF

116. Line HCFA Type Service Code CHAR   1   Code indicating the type of service, as defined
                                                      in the HCFA Medicare Carrier Manual, for this
                                                      line item on the non-institutional claim.

                                                      DB2 ALIAS: HCFA_TYPE_SRVC_CD
                                                      SAS ALIAS: TYPSRVCB
                                                      STANDARD ALIAS: LINE_HCFA_TYPE_SRVC_CD
                                                      SYSTEM ALIAS: LTTOS

TITLE ALIAS: HCFA_TYPE_SRVC

EDIT-RULES:
The only type of service codes applicable to DMERC
claims are: 1, 9, A, E, G, H, J, K, L, M, P,
R, and S.

CODES:
  REFER TO: HCFA_TYPE_SRVC_TB
            IN THE CODES APPENDIX

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					COMMENT: Prior to Version H this field was named: CWFB_HCFA_TYPE_SRVC_CD.
					SOURCE: CWF
117. Carrier Line Type Service Code	CHAR	2			Carrier's type of service code (usually different from HCFA's) used for pricing the service reported on the line item on the carrier claim (non-DMERC).
					DB2 ALIAS: LINE_TYPE_SRVC_CD SAS ALIAS: PTYPESRV STANDARD ALIAS: CARR_LINE_TYPE_SRVC_CD TITLE ALIAS: CARR_TYPE_SRVC
					COMMENT: Prior to Version H this field was named: CWFB_CARR_TYPE_SRVC_CD.
					SOURCE: CWF
118. Line Place Of Service Code	CHAR	2			The code indicating the place of service, as defined in the Medicare Carrier Manual, for this line item on the noninstitutional claim.
					COMMON ALIAS: POS DB2 ALIAS: LINE_PLC_SRVC_CD SAS ALIAS: PLCSRVC

```
                              carrier.txt
                         STANDARD ALIAS: LINE_PLC_SRVC_CD
                         TITLE ALIAS: PLC_SRVC

                         CODES:
                           REFER TO: LINE_PLC_SRVC_TB
                                     IN THE CODES APPENDIX

                         COMMENT:
                         Prior to Version H this field was named:
                         CWFB_PLC_SRVC_CD.

                         SOURCE:
                         CWF
    119. Carrier Line Pricing        CHAR      2            Code denoting the carrier-specific locality
         Locality Code                                      used for pricing the service for this line
                                                            item on the carrier claim (non-DMERC).

                                                            DB2 ALIAS: PRCNG_LCLTY_CD
                                                            SAS ALIAS: LCLTY_CD
                                                            STANDARD ALIAS: CARR_LINE_PRCNG_LCLTY_CD
                                                            TITLE ALIAS: PRICING_LOCALITY
1                        Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                          POSITIONS
              NAME                TYPE  LENGTH BEG   END                          CONTENTS
    ----------------------------  ----  ------ ---------  -------------------------------------------------------

                                                            EDIT-RULES:
                                                            CARRIER INFORMATION FILE

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            CWFB_CARR_PRCNG_LCLTY_CD.

                                                            SOURCE:
                                                            CWF

    120. Line First Expense Date     NUM       8            Beginning date (1st expense) for this line item
                                                            service on the noninstitutional
                                                            claim.

                                                            8 DIGITS UNSIGNED

                                                            DB2 ALIAS: LINE_1ST_EXPNS_DT
                                                            SAS ALIAS: EXPNSDT1
                                                            STANDARD ALIAS: LINE_1ST_EXPNS_DT
```

TITLE ALIAS: 1ST_EXPNS_DT

EDIT-RULES:
YYYYMMDD

COMMENT:
Prior to Version H this field was named:
CWFB_1ST_EXPNS_DT.

SOURCE:
CWF

121. Line Last Expense Date   NUM   8   The ending date (last expense) for the line
item service on the noninstitutional claim.

8 DIGITS UNSIGNED

COBOL ALIAS: LST_EXP_DT
DB2 ALIAS: LINE_LAST_EXPNS_DT
SAS ALIAS: EXPNSDT2
STANDARD ALIAS: LINE_LAST_EXPNS_DT
TITLE ALIAS: LAST_EXPNS_DT

EDIT-RULES:
YYYYMMDD

COMMENT:
Prior to Version H this field was named:
CWFB_LAST_EXPNS_DT.

SOURCE:
CWF

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NAME	TYPE	LENGTH	POSITIONS BEG END	CONTENTS
122. Line HCPCS Code	CHAR	5		The Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products and services which may be provided to Medicare beneficiaries and to individuals enrolled in private health insurance programs. The codes are divided into three levels, or groups, as described below:

DB2 ALIAS: LINE_HCPCS_CD
SAS ALIAS: HCPCS_CD
STANDARD ALIAS: LINE_HCPCS_CD
TITLE ALIAS: HCPCS_CD

COMMENT:
Prior to Version H this line item field was
named: HCPCS_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
noninstitutional: LINE).

Level I
    Codes and descriptors copyrighted by the American
    Medical Association's Current Procedural
    Terminology, Fourth Edition (CPT-4). These are
    5 position numeric codes representing physician
    and nonphysician services.

    **** Note: ****
    CPT-4 codes including both long and short
    descriptions shall be used in accordance with the
    HCFA/AMA agreement. Any other use violates the
    AMA copyright.

Level II
    Includes codes and descriptors copyrighted by
    the American Dental Association's Current Dental
    Terminology, Second Edition (CDT-2). These are
    5 position alpha-numeric codes comprising
    the D series. All other level II codes and
    descriptors are approved and maintained jointly
    by the alpha-numeric editorial panel (consisting
    of HCFA, the Health Insurance Association of
    America, and the Blue Cross and Blue Shield
    Association). These are 5 position alpha-
    numeric codes representing primarily items and
    nonphysician services that are not
    represented in the level I codes.

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                                    POSITIONS
            NAME   TYPE LENGTH BEG END   CONTENTS
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carrier.txt
            Level III
               Codes and descriptors developed by Medicare
               carriers for use at the local (carrier) level.
               These are 5 position alpha-numeric codes in the
               W, X, Y or Z series representing physician
               and nonphysician services that are not
               represented in the level I or level II codes.

123. Line HCPCS Initial Modifier CHAR   2   A first modifier to the HCPCS procedure code
     Code   to enable a more specific procedure
                                                      identification for the line item service
                                                      on the noninstitutional claim.

                                                      DB2 ALIAS: HCPCS_1ST_MDFR_CD
                                                      SAS ALIAS: MDFR_CD1
                                                      STANDARD ALIAS: LINE_HCPCS_INITL_MDFR_CD
                                                      TITLE ALIAS: INITIAL_MODIFIER

                                                      EDIT-RULES:
                                                      CARRIER INFORMATION FILE

                                                      COMMENT:
                                                      Prior to Version H this field was named:
                                                      HCPCS_INITL_MDFR_CD. With Version H, a prefix
                                                      was added to denote the location of this field
                                                      on each claim type (institutional: REV_CNTR and
                                                      noninstitutional: LINE).

                                                      SOURCE:
                                                      CWF

124. Line HCPCS Second Modifier   CHAR   2   A second modifier to the HCPCS procedure code to
     Code   make it more specific than the first modifier
                                                      code to identify the line item procedures for
                                                      this claim.

                                                      DB2 ALIAS: HCPCS_2ND_MDFR_CD
                                                      SAS ALIAS: MDFR_CD2
                                                      STANDARD ALIAS: LINE_HCPCS_2ND_MDFR_CD
                                                      TITLE ALIAS: SECOND_MODIFIER

                                                      EDIT-RULES:
                                                      CARRIER INFORMATION FILE

                                                      COMMENT:
                                                      Prior to Version H this field was named:

HCPCS_2ND_MDFR_CD. With Version H, a prefix
was added to denote the location of this field
on each claim type (institutional: REV_CNTR and
noninstitutional: LINE).

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                                          POSITIONS
            NAME                TYPE  LENGTH BEG   END                          CONTENTS
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                                                       SOURCE:
                                                       CWF

  125. Line NCH BETOS Code      CHAR    3              Effective with Version H, the Berenson-Eggers
                                                       type of service (BETOS) for the procedure code
                                                       based on generally agreed upon clinically
                                                       meaningful groupings of procedures and services.
                                                       This field is included as a line item on the
                                                       noninstitutional claim.

                                                       NOTE:  During the Version H conversion this field
                                                       was populated with data throughout history (back
                                                       to service year 1991).

                                                       DB2 ALIAS: LINE_NCH_BETOS_CD
                                                       SAS ALIAS: BETOS
                                                       STANDARD ALIAS: LINE_NCH_BETOS_CD
                                                       SYSTEM ALIAS: LTBETOS
                                                       TITLE ALIAS: BETOS

                                                       DERIVATION:
                                                       DERIVED FROM:
                                                          LINE_HCPCS_CD
                                                          LINE_HCPCS_INITL_MDFR_CD
                                                          LINE_HCPCS_2ND_MDFR_CD
                                                          HCPCS MASTER FILE

                                                       DERIVATION RULES:
                                                       Match the HCPCS on the claim to the HCPCS on
                                                       the HCPCS Master File to obtain the BETOS code.

                                                       CODES:
                                                         REFER TO: BETOS_TB
                                                                   IN THE CODES APPENDIX

                                                       SOURCE:
                                                       NCH
```

126. Line IDE Number   CHAR   7   Effective with Version H, the exemption number assigned by the Food and Drug Administration (FDA) to an investigational device after a manufacturer has been approved by FDA to conduct a clinical trial on that device.   HCFA established a new policy of covering certain IDE's which was implemented in claims processing on 10/1/96 (which is NCH weekly process 10/4/96) for service dates beginning 10/1/95.

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NAME	TYPE	LENGTH	BEG	END	CONTENTS

NOTE: Prior to Version H a dummy line item was created in the last occurrence of line item group to store IDE.   The IDE number was housed in two fields: HCPCS code and HCPCS initial modifier; the second modifier contained the value 'ID'. There will be only one distinct IDE number reported on the non-institutional claim. During the Version H conversion, the IDE was moved from the dummy line item to its own dedicated field for each line item (i.e., the IDE was repeated on all line items on the claim.)

DB2 ALIAS: LINE_IDE_NUM
SAS ALIAS: LINE_IDE
STANDARD ALIAS: LINE_IDE_NUM
TITLE ALIAS: IDE_NUMBER

SOURCE:
CWF

127. Line National Drug Code   CHAR   11   Effective 1/1/94 on the DMERC claim, the National Drug Code identifying the oral anti-cancer drugs. Effective with Version H, this line item field was added as a placeholder on the carrier claim.

DB2 ALIAS: LINE_NATL_DRUG_CD
SAS ALIAS: NDC_CD
STANDARD ALIAS: LINE_NATL_DRUG_CD
TITLE ALIAS: NDC_CD

SOURCE:

CWF

128. Line NCH Payment Amount   PACK   6   Amount of payment made from the trust funds (after
                                                         deductible and coinsurance amounts have been
                                                         paid) for the line item service on the non-
                                                         institutional claim.

                                                         9.2 DIGITS SIGNED

                                                         COMMON ALIAS: REIMBURSEMENT
                                                         DB2 ALIAS: LINE_NCH_PMT_AMT
                                                         SAS ALIAS: LINEPMT
                                                         STANDARD ALIAS: LINE_NCH_PMT_AMT
                                                         TITLE ALIAS: REIMBURSEMENT

                                                         EDIT-RULES:
                                                         $$$$$$$$$CC

                                                         COMMENT:
                                                         Prior to Version H this line item field was named:
                                                         CLM_PMT_AMT and the size of this field was
                                                         S9(7)V99.

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          NAME   TYPE   LENGTH BEG   END   CONTENTS
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                                                         SOURCE:
                                                         NCH

129. Line Beneficiary Payment   PACK   6   Effective with Version H, the payment (reim-
     Amount   bursement) made to the beneficiary related
                                                         to the line item service on the noninstitu-
                                                         tional claim.

                                                         NOTE: Beginning with NCH weekly process date
                                                         10/3/97 this field was populated with data.
                                                         Claims processed prior to 10/3/97 will contain
                                                         zeroes in this field.

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: LINE_BENE_PMT_AMT
                                                         SAS ALIAS: LBENPMT
                                                         STANDARD ALIAS: LINE_BENE_PMT_AMT
                                                         TITLE ALIAS: BENE_PMT_AMT

SOURCE:
CWF

130. Line Provider Payment   PACK   6   Effective with Version H, the payment
     Amount   made to the provider for the line item
                                                     service on the noninstitutional claim.

                                                     NOTE: Beginning with NCH weekly process date
                                                     10/3/97 this field was populated with data.
                                                     Claims processed prior to 10/3/97 will contain
                                                     zeroes in this field.

                                                     9.2 DIGITS SIGNED

                                                     DB2 ALIAS: LINE_PRVDR_PMT_AMT
                                                     SAS ALIAS: LPRVPMT
                                                     STANDARD ALIAS: LINE_PRVDR_PMT_AMT
                                                     TITLE ALIAS: PRVDR_PMT_AMT

                                                     SOURCE:
                                                     CWF

131. Line Beneficiary Part B   PACK   6   The amount of money for which the
     Deductible Amount   carrier has determined that the beneficiary
                                                     is liable for the Part B cash deductible
                                                     for the line item service on the noninstitutional
                                                     claim.

                                                     9.2 DIGITS SIGNED

                                                     DB2 ALIAS: LINE_DDCTBL_AMT
                                                     SAS ALIAS: LDEDAMT
                                                     STANDARD ALIAS: LINE_BENE_PTB_DDCTBL_AMT
                                                     TITLE ALIAS: PTB_DED_AMT

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             NAME   TYPE LENGTH BEG   END   CONTENTS
     --------------------------- ---- ------ --------- ---

                                                     EDIT-RULES:
                                                     $$$$$$$$$CC

                                                     COMMENT:
                                                     Prior to Version H this field was named:
                                                     BENE_PTB_DDCTBL_LBLTY_AMT and the size of the
                                                     field was S9(3)V99.

SOURCE:
CWF

132. Line Beneficiary Primary   CHAR   1   The code specifying a federal non-Medicare program
     Payer Code   or other source that has primary responsibility
                                                          for the payment of the Medicare beneficiary's
                                                          medical bills relating to the line item service
                                                          on the noninstitutional claim.

                                                          DB2 ALIAS: LINE_PRMRY_PYR_CD
                                                          SAS ALIAS: LPRPAYCD
                                                          STANDARD ALIAS: LINE_BENE_PRMRY_PYR_CD
                                                          TITLE ALIAS: PRIMARY_PAYER_CD

                                                          CODES:
                                                            REFER TO: BENE_PRMRY_PYR_TB
                                                                      IN THE CODES APPENDIX

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          BENE_PRMRY_PYR_CD.

                                                          SOURCE:
                                                          CWF,VA,DOL,SSA

133. Line Beneficiary Primary   PACK   6   The amount of a payment made on behalf of a
     Payer Paid Amount   Medicare beneficiary by a primary payer other
                                                          than Medicare, that the provider is applying
                                                          to covered Medicare charges for to the line
                                                          ITEM SERVICE ON THE NONINSTITUTIONAL.

                                                          9.2 DIGITS SIGNED

                                                          DB2 ALIAS: LINE_PRMRY_PYR_PD
                                                          SAS ALIAS: LPRPDAMT
                                                          STANDARD ALIAS: LINE_BENE_PRMRY_PYR_PD_AMT
                                                          TITLE ALIAS: PRMRY_PYR_PD

                                                          EDIT-RULES:
                                                          $$$$$$$$$CC

                                                          COMMENT:
                                                          Prior to Version H this field was named:
                                                          BENE_PRMRY_PYR_PMT_AMT and the field size

                                        POSITIONS

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            NAME                   TYPE  LENGTH BEG  END                              CONTENTS
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was S9(5)V99.

SOURCE:
CWF

134. Line Coinsurance Amount   PACK   6   Effective with Version H, the beneficiary
                                                            coinsurance liability amount for this line
                                                            item service on the noninstitutional claim.

                                                            NOTE: Beginning with NCH weekly process date
                                                            10/3/97 this field was populated with data.
                                                            Claims processed prior to 10/3/97 will contain
                                                            zeroes in this field.

                                                            9.2 DIGITS SIGNED

                                                            DB2 ALIAS: LINE_COINSRNC_AMT
                                                            SAS ALIAS: COINAMT
                                                            STANDARD ALIAS: LINE_COINSRNC_AMT
                                                            TITLE ALIAS: COINSRNC_AMT

                                                            SOURCE:
                                                            CWF

135. Carrier Line Psychiatric,   PACK   6   For type of service psychiatric, occupational
     Occupational Therapy,   therapy or physical therapy, the amount of
     Physical Therapy Limit   allowed charges applied toward the limit cap
     Amount   for this line item service on the noninstitutional
                                                            claim.

                                                            9.2 DIGITS SIGNED

                                                            DB2 ALIAS: PSYCH_OT_PT_LMT
                                                            SAS ALIAS: LLMTAMT
                                                            STANDARD ALIAS: CARR_LINE_PSYCH_OT_PT_LMT_AMT
                                                            TITLE ALIAS: PSYCH_OT_PT_LIMIT

                                                            COMMENT:
                                                            Prior to Version H this field was named:
                                                            CWFB_PSYCH_OT_PT_LMT_AMT and the field size
                                                            was S9(5)V99.

                                                            SOURCE:
                                                            CWF

136. Line Interest Amount   PACK   6   Amount of interest to be paid for this line

item service on the noninstitutional claim.
**NOTE: This is not included in the line item
NCH payment (reimbursement) amount.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_INTRST_AMT
SAS ALIAS: LINT_AMT
STANDARD ALIAS: LINE_INTRST_AMT
TITLE ALIAS: INTRST_AMT

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NAME	TYPE	LENGTH	BEG	END	CONTENTS

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H this field was named:
CWFB_INTRST_AMT and the field size was
S9(5)V99.

SOURCE:
CWF

137. Line Primary Payer Allowed   PACK   6   Effective with Version H, the primary payer
     Charge Amount   allowed charge amount for the line item
                                                           service on the noninstitutional claim.

                                                           NOTE: Beginning with NCH weekly process date
                                                           10/3/97 this field was populated with data.
                                                           Claims processed prior to 10/3/97 will contain
                                                           zeroes in this field.

                                                           9.2 DIGITS SIGNED

                                                           DB2 ALIAS: PRMRY_PYR_ALOW_AMT
                                                           SAS ALIAS: PRPYALOW
                                                           STANDARD ALIAS: LINE_PRMRY_PYR_ALOW_CHRG_AMT
                                                           TITLE ALIAS: PRMRY_PYR_ALOW_CHRG

                                                           SOURCE:
                                                           CWF

138. Line 10% Penalty Reduction   PACK   6   Effective with Version H, the 10% payment
     Amount   reduction amount (applicable to a late

filing claim) for the line item service.
on the noninstitutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: TENPCT_PNLTY_AMT
SAS ALIAS: PNLTYAMT
STANDARD ALIAS: LINE_10PCT_PNLTY_RDCTN_AMT
TITLE ALIAS: TENPCT_PNLTY

SOURCE:
CWF

	NAME	TYPE	LENGTH	CONTENTS
139.	Carrier Line Blood Deductible Pints Quantity	PACK	2	The blood pints quantity (deductible) for the line item on the carrier claim (non-DMERC).

3 DIGITS SIGNED

DB2 ALIAS: LINE_BLOOD_DDCTBL
SAS ALIAS: LBLD_DED
STANDARD ALIAS: CARR_LINE_BLOOD_DDCTBL_QTY
TITLE ALIAS: BLOOD_DDCTBL

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                              POSITIONS
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```

EDIT-RULES:
NUMERIC

COMMENT:
Prior to Version H this field was named:
CWFB_LINE_BLOOD_DDCTBL_QTY.

SOURCE:
CWF

	NAME	TYPE	LENGTH	CONTENTS
140.	Line Submitted Charge Amount	PACK	6	The amount of submitted charges for the line item service on the noninstitutional claim.

9.2 DIGITS SIGNED

DB2 ALIAS: LINE_SBMT_CHRG_AMT
SAS ALIAS: LSBMTCHG
STANDARD ALIAS: LINE_SBMT_CHRG_AMT
TITLE ALIAS: SBMT_CHRG

EDIT-RULES:
$$$$$$$$$CC

COMMENT:
Prior to Version H this field was named:
CWFB_SBMT_CHRG_AMT and the field size was
S9(5)V99.

SOURCE:
CWF

141. Line Allowed Charge Amount   PACK   6   The amount of allowed charges for the line
                                                         item service on the noninstitutional claim. This
                                                         charge is used to compute pay to providers or
                                                         reimbursement to beneficiaries. **NOTE: The
                                                         allowed charge is determined by the lower of
                                                         three charges: prevailing, customary or actual.

                                                         9.2 DIGITS SIGNED

                                                         DB2 ALIAS: LINE_ALOW_CHRG_AMT
                                                         SAS ALIAS: LALOWCHG
                                                         STANDARD ALIAS: LINE_ALOW_CHRG_AMT
                                                         TITLE ALIAS: ALOW_CHRG

                                                         EDIT-RULES:
                                                         $$$$$$$$CC

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         CWFB_ALOW_CHRG_AMT and the field size was
                                                         S9(5)V99.

                                                         SOURCE:
                                                         CWF

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

| | | | POSITIONS | | |
NAME	TYPE	LENGTH	BEG	END	CONTENTS

142. Carrier Line Clinical Lab   CHAR   10   The identification number assigned to the
     Number   clinical laboratory providing services for
                                                       the line item on the carrier claim (non-DMERC).

                                                       DB2 ALIAS: CLNCL_LAB_NUM
                                                       SAS ALIAS: LAB_NUM

carrier.txt
STANDARD ALIAS: CARR_LINE_CLNCL_LAB_NUM
TITLE ALIAS: LAB_NUM

COMMENT:
Prior to Version H this field was named:
CWFB_CLNCL_LAB_NUM.

SOURCE:
CWF

143. Carrier Line Clinical Lab   PACK   6   Fee schedule charge amount applied for the line
     Charge Amount   item clinical laboratory service on the carrier
                                                   claim (non-DMERC).

                                                   9.2 DIGITS SIGNED

                                                   DB2 ALIAS: CLNCL_LAB_CHRG_AMT
                                                   SAS ALIAS: LAB_AMT
                                                   STANDARD ALIAS: CARR_LINE_CLNCL_LAB_CHRG_AMT
                                                   TITLE ALIAS: LAB_CHRG

                                                   EDIT-RULES:
                                                   $$$$$$$$C

                                                   COMMENT:
                                                   Prior to Version H this field was named:
                                                   CWFB_CLNCL_LAB_CHRG_AMT and the field size was
                                                   S9(5)V99.

                                                   SOURCE:
                                                   CWF

144. Line Processing Indicator   CHAR   1   The code indicating the reason a line item
     Code   on the noninstitutional claim was allowed
                                                   or denied.

                                                   DB2 ALIAS: LINE_PRCSG_IND_CD
                                                   SAS ALIAS: PRCNGIND
                                                   STANDARD ALIAS: LINE_PRCSG_IND_CD
                                                   TITLE ALIAS: PRCSG_IND

                                                   CODES:
                                                     REFER TO: LINE_PRCSG_IND_TB
                                                               IN THE CODES APPENDIX

                                                   COMMENT:
                                                   Prior to Version H this field was named:
                                                   CWFB_PRCSG_IND_CD.

```
                                          POSITIONS
              NAME               TYPE   LENGTH BEG  END                            CONTENTS
-----------------------------    ----   ------ ---------    ------------------------------------------------------------
```

                                                           SOURCE:
                                                           CWF

145. Line Payment 80%/100% Code CHAR   1   The code indicating that the amount shown in the
                                                           payment field on the noninstitutional line item
                                                           represents either 80% or 100% of the allowed
                                                           charges less any deductible, or 100% limitation
                                                           of liability only.

                                                           COMMON ALIAS: REIMBURSEMENT_IND
                                                           DB2 ALIAS: LINE_PMT_80_100_CD
                                                           SAS ALIAS: PMTINDSW
                                                           STANDARD ALIAS: LINE_PMT_80_100_CD
                                                           TITLE ALIAS: REINBURSEMENT_IND

                                                           CODES:
                                                           0 = 80%
                                                           1 = 100%
                                                           3 = 100% Limitation of liability only

                                                           COMMENT:
                                                           Prior to Version H this field was named:
                                                           CWFB_PMT_80_100_CD.

                                                           SOURCE:
                                                           CWF

146. Line Service Deductible   CHAR   1   Switch indicating whether or not the line item
     Indicator Switch   service on the noninstitutional claim is subject
                                                           to a deductible.

                                                           DB2 ALIAS: SRVC_DDCTBL_SW
                                                           SAS ALIAS: DED_SW
                                                           STANDARD ALIAS: LINE_SRVC_DDCTBL_IND_SW
                                                           TITLE ALIAS: SRVC_DED_IND

                                                           CODES:
                                                           0 = Service subject to deductible
                                                           1 = Service not subject to deductible

                                                           COMMENT:
                                                           Prior to Version H this field was named:

carrier.txt
CWFB_SRVC_DDCTBL_IND_SW.

SOURCE:
CWF

147. Line Payment Indicator Code CHAR   1   Code that indicates the payment screen used to
                                                           determine the allowed charge for the line item
                                                           service on the noninstitutional claim.

                                                           DB2 ALIAS: LINE_PMT_IND_CD
                                                           SAS ALIAS: PMTINDCD
                                                           STANDARD ALIAS: LINE_PMT_IND_CD
                                                           TITLE ALIAS: PMT_IND

                                          POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
    ----------------------------   ---- ------ ---------   --

                                                           CODES:
                                                             REFER TO: LINE_PMT_IND_TB
                                                                       IN THE CODES APPENDIX

                                                           COMMENT:
                                                           Prior to Version H this field was named:
                                                           CWFB_PMT_IND_CD.

                                                           SOURCE:
                                                           CWF

148. Carrier Line   PACK   2   The count of the total units associated with
     Miles/Time/Units/Services   services needing unit reporting such as
     Count   transportation, miles, anesthesia time units,
                                                            number of services, volume of oxygen or blood
                                                            units. This is a line item field on the carrier
                                                            claim (non-DMERC) and is used for both allowed
                                                            and denied services.

                                                           3 DIGITS SIGNED

                                                           DB2 ALIAS: LINE_MTUS_CNT
                                                           SAS ALIAS: MTUS_CNT
                                                           STANDARD ALIAS: CARR_LINE_MTUS_CNT
                                                           TITLE ALIAS: MTUS_CNT

                                                           EDIT-RULES:
                                                           For CARR_LINE_MTUS_IND_CD equal to 2 (anesthesia
                                                           time units) there is one implied decimal point.

COMMENT:
Prior to Version H this field was named:
CWFB_MTUS_CNT.

SOURCE:
CWF

149. Carrier Line   CHAR   1   Code indicating the units associated with
     Miles/Time/Units/Services   services needing unit reporting on the line
     Indicator Code   item for the carrier claim (non-DMERC).

                                                         DB2 ALIAS: LINE_MTUS_IND_CD
                                                         SAS ALIAS: MTUS_IND
                                                         STANDARD ALIAS: CARR_LINE_MTUS_IND_CD
                                                         TITLE ALIAS: MTUS_IND

                                                         CODES:
                                                         0 = Values reported as zero (no allowed
                                                             activities)
                                                         1 = Transportation (ambulance) miles
                                                         2 = Anesthesia time units
                                                         3 = Services
                                                         4 = Oxygen units
                                                         5 = Units of blood

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                        POSITIONS
              NAME   TYPE LENGTH BEG END   CONTENTS
     ---------------------------   ---- ------ --------- --

                                                         6 = Anesthesia base and time units (prior
                                                             to 1991; from BMAD)

                                                         COMMENT:
                                                         Prior to Version H this field was named:
                                                         CWFB_MTUS_IND_CD.

                                                         SOURCE:
                                                         CWF

150. Line Diagnosis Code   CHAR   5   The ICD-9-CM code indicating the diagnosis
                                                         supporting this line item procedure/service
                                                         on the noninstitutional claim.

                                                         DB2 ALIAS: LINE_DGNS_CD
                                                         SAS ALIAS: LINEDGNS
                                                         STANDARD ALIAS: LINE_DGNS_CD

carrier.txt
TITLE ALIAS: DGNS_CD

EDIT-RULES:
ICD-9-CM

COMMENT:
Prior to Version H this field was named:
CWFB_LINE_DGNS_CD.

SOURCE:
CWF

151. FILLER   CHAR   1

152. Carrier Line Anesthesia   PACK   2   The base number of units assigned to the line
     Base Unit Count   item anesthesia procedure on the carrier claim
                                                        (non-DMERC).

                                                        3 DIGITS SIGNED

                                                        DB2 ALIAS: ANSTHSA_UNIT_CNT
                                                        SAS ALIAS: ANSTHUNT
                                                        STANDARD ALIAS: CARR_LINE_ANSTHSA_UNIT_CNT
                                                        TITLE ALIAS: ANSTHSA_UNITS

                                                        COMMENT:
                                                        Prior to Version H this field was named:
                                                        CWFB_ANSTHSA_BASE_UNIT_CNT.

                                                        SOURCE:
                                                        CWF

153. Carrier Line CLIA Alert   CHAR   1   Effective with Version G, the alert code (resulting
     Indicator Code   from CLIA editing) added by CWF as a line item
                                                        on the carrier claim (non-DMERC).

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                            POSITIONS
            NAME   TYPE   LENGTH BEG   END   CONTENTS
    --------------------------- ----   ------ ---------   --

                                                        DB2 ALIAS: CLIA_ALERT_IND_CD
                                                        SAS ALIAS: CLIAALRT
                                                        STANDARD ALIAS: CARR_LINE_CLIA_ALERT_IND_CD
                                                        TITLE ALIAS: CLIA_ALERT

                                                        CODES:
                                                            Page 84

```
                                       carrier.txt
                             (Effective 9/92 but not stored until 10/93)
                             0 = No Alert
                             1 = 77X9
                             2 = 77XA
                             3 = 77X5
                             4 = 77X6
                             5 = 77X7
                             6 = 77X8
                             7 = 77XB


                             COMMENT:
                             Prior to Version H this field was named:
                             CWFB_CLIA_ALERT_IND_CD.

                             SOURCE:
                             CWF
```

154. Line Additional Claim   CHAR   1   Effective 5/92, the code indicating additional
     Documentation Indicator   claim documentation was submitted for this line
     Code   item service on the noninstitutional claim.

                                                             COMMON ALIAS: DOCUMENT_IND
                                                             DB2 ALIAS: ADDTNL_DCMTN_CD
                                                             SAS ALIAS: DCMTN_CD
                                                             STANDARD ALIAS: LINE_ADDTNL_CLM_DCMTN_IND_CD
                                                             TITLE ALIAS: ADDTNL_DCMTN_IND

                                                             EDIT-RULES:
                                                             In any case where more than one value is
                                                             applicable, highest number is shown.

                                                             CODES:
                                                               REFER TO: LINE_ADDTNL_CLM_DCMTN_IND_TB
                                                                         IN THE CODES APPENDIX

                                                             COMMENT:
                                                             Prior to Version H this field was named:
                                                             CWFB_ADDTNL_CLM_DCMTN_IND_CD.

                                                             SOURCE:
                                                             CWF

155. Carrier Line DME Coverage   NUM   8   Effective 5/92 through 6/94, as line item on the
     Period Start Date   carrier claim (non-DMERC), the date durable medical
                                                              equipment (DME) coverage period started per certi-
                                                              ficate of medical necessity, prescription, other
                                                              documentation or carrier determination. This field
                                                              is applicable to line items involving DME,

```
                                POSITIONS
           NAME              TYPE  LENGTH BEG  END                          CONTENTS
---------------------------  ----  ------ ---------  ------------------------------------------------------------
```

                                                        suppressive drugs, pen, ESRD and oxygen items
                                                        referred to as DMEPOS).

                                                        8 DIGITS UNSIGNED

                                                        DB2 ALIAS: DME_CVRG_STRT_DT
                                                        SAS ALIAS: DMEST_DT
                                                        STANDARD ALIAS: CARR_LINE_DME_CVRG_PRD_STRT_DT
                                                        TITLE ALIAS: DME_CVRG_START_DT

                                                        EDIT-RULES:
                                                        YYYYMMDD

                                                        COMMENT:
                                                        Prior to Version H this field was named:
                                                        CWFB_DME_CVRG_PRD_STRT_DT.

                                                        SOURCE:
                                                        CWF

                                                        LIMITATIONS:
                                                        When the revised DME processing was implemented
                                                        (phased in between 10/93-6/94), this field was not
                                                        included on the new DMERC claim; it is being
                                                        reported on the certificate of medical necessity
                                                        (CMN) transaction. HCFA does not receivee CMN
                                                        transaction from CWF.

156. Line DME Purchase Price   PACK   6   Effective 5/92, the amount representing the
     Amount   lower of fee schedule for purchase of new or
                                                        used DME, or actual charge. In case of rental
                                                        DME, this amount represents the purchase cap;
                                                        rental payments can only be made until the
                                                        cap is met. This line item field is applicable
                                                        to non-institutional claims involving DME,
                                                        prosthetic, orthotic and supply items,
                                                        immunosuppressive drugs, pen, ESRD and oxygen
                                                        items referred to as DMEPOS.

                                                        9.2 DIGITS SIGNED

```
                         carrier.txt
                 DB2 ALIAS: DME_PURC_PRICE_AMT
                 SAS ALIAS: DME_PURC
                 STANDARD ALIAS: LINE_DME_PURC_PRICE_AMT
                 TITLE ALIAS: DME_PURC_PRICE

                 EDIT-RULES:
                 $$$$$$$$$$CC

                 COMMENT:
                 Prior to Version H this field was named:
                 CWFB_DME_PURC_PRICE_AMT and the field size
                 was S9(5)V99.
```

1   Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

			POSITIONS		
NAME	TYPE	LENGTH	BEG	END	CONTENTS
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```
                                                 SOURCE:
                                                 CWF

  157. Carrier Line DME Medical    PACK     2              Effective 5/92 through 6/94, as line item on the
       Necessity Month Count                               carrier claim (non-DMERC), the count determined by
                                                           the carrier showing the length of need (medical
                                                           necessity for DME in months from the start date
                                                           through the determined period of need.
                                                           This field is applicable to line items involving
                                                           DME, prosthetic, orthotic and supply items, immuno-
                                                           suppressive drugs, pen, ESRD and oxygen items
                                                           referred to as DMEPOS).

                                                 Exception:  If the DME is determined to be
                                                             medically necessary for the life
                                                             of the beneficiary, 99 is placed
                                                             in this field, rather than a month
                                                             count.

                                                 3 DIGITS SIGNED

                                                 DB2 ALIAS: DME_NCSTY_MO_CNT
                                                 SAS ALIAS: NCSTY_MO
                                                 STANDARD ALIAS: CARR_LINE_DME_NCSTY_MO_CNT
                                                 TITLE ALIAS: DME_NCSTY_MONTHS

                                                 COMMENT:
                                                 Prior to Version H this field was named:
```

```
                                    carrier.txt
                              CWFB_DME_MDCL_NCSTY_MO_CNT.

                              SOURCE:
                              CWF

                              LIMITATIONS:
                              When the revised DME processing was implemented
                              (phased in between 10/93-6/94), this field was not
                              included on the new DMERC claim; it is being
                              reported on the certificate of medical necessity
                              (CMN) transaction.  HCFA does not receive CMN
                              transaction from CWF.

  158. FILLER                    CHAR     50

  159. End of Record Code        CHAR      3            Effective with Version 'I', the code used
                                                        to identify the end of a record/segment or
                                                        the end of the claim.

                                                        DB2 ALIAS: END_REC_CD
                                                        SAS ALIAS: EOR
                                                        STANDARD ALIAS: END_REC_CD
                                                        TITLE ALIAS: END_OF_REC

1                    Carrier Claim Record -- FROM CMS DATA DICTIONARY -- 10/2002

                                        POSITIONS
              NAME                TYPE  LENGTH BEG   END                          CONTENTS
    --------------------------- ----  ------ --------   -------------------------------------------------------

                                                        CODES:
                                                        EOR = End of Record/Segment
                                                        EOC= End of Claim

                                                        COMMENT:
                                                        Prior to Version I this field was named:
                                                        END_REC_CNSTNT.

                                                        SOURCE:
                                                        NCH

1      BENE_IDENT_TB                       Beneficiary Identification Code (BIC) Table
       -------------                       --------------------------------------------


                      Social Security Administration:

                      A  = Primary claimant
```

```
B  = Aged wife, age 62 or over (1st
     claimant)
B1 = Aged husband, age 62 or over (1st
     claimant)
B2 = Young wife, with a child in her care
     (1st claimant)
B3 = Aged wife (2nd claimant)
B4 = Aged husband (2nd claimant)
B5 = Young wife (2nd claimant)
B6 = Divorced wife, age 62 or over (1st
     claimant)
B7 = Young wife (3rd claimant)
B8 = Aged wife (3rd claimant)
B9 = Divorced wife (2nd claimant)
BA = Aged wife (4th claimant)
BD = Aged wife (5th claimant)
BG = Aged husband (3rd claimant)
BH = Aged husband (4th claimant)
BJ = Aged husband (5th claimant)
BK = Young wife (4th claimant)
BL = Young wife (5th claimant)
BN = Divorced wife (3rd claimant)
BP = Divorced wife (4th claimant)
BQ = Divorced wife (5th claimant)
BR = Divorced husband (1st claimant)
BT = Divorced husband (2nd claimant)
BW = Young husband (2nd claimant)
BY = Young husband (1st claimant)
C1-C9,CA-CZ = Child (includes minor, student
              or disabled child)
D  = Aged widow, 60 or over (1st claimant)
D1 = Aged widower, age 60 or over (1st
     claimant)
D2 = Aged widow (2nd claimant)
D3 = Aged widower (2nd claimant)
D4 = Widow (remarried after attainment of
     age 60) (1st claimant)
D5 = Widower (remarried after attainment of
     age 60) (1st claimant)
D6 = Surviving divorced wife, age 60 or over
     (1st claimant)
D7 = Surviving divorced wife (2nd claimant)
D8 = Aged widow (3rd claimant)
D9 = Remarried widow (2nd claimant)
DA = Remarried widow (3rd claimant)
DC = Surviving divorced husband (1st claimant)
DD = Aged widow (4th claimant)
DG = Aged widow (5th claimant)
```

```
                                  DH = Aged widower (3rd claimant)
                                  DJ = Aged widower (4th claimant)
                                  DK = Aged widower (5th claimant)
                                  DL = Remarried widow (4th claimant)
                                  DM = Surviving divorced husband (2nd
                                       claimant)
   1      BENE_IDENT_TB                      Beneficiary Identification Code (BIC) Table
          -------------                      -------------------------------------------

                                  DN = Remarried widow (5th claimant)
                                  DP = Remarried widower (2nd claimant)
                                  DQ = Remarried widower (3rd claimant)
                                  DR = Remarried widower (4th claimant)
                                  DS = Surviving divorced husband (3rd
                                       claimant)
                                  DT = Remarried widower (5th claimant)
                                  DV = Surviving divorced wife (3rd claimant)
                                  DW = Surviving divorced wife (4th claimant)
                                  DX = Surviving divorced husband (4th
                                       claimant)
                                  DY = Surviving divorced wife (5th claimant)
                                  DZ = Surviving divorced husband (5th
                                       claimant)
                                  E  = Mother (widow) (1st claimant)
                                  E1 = Surviving divorced mother (1st
                                       claimant)
                                  E2 = Mother (widow) (2nd claimant)
                                  E3 = Surviving divorced mother (2nd
                                       claimant)
                                  E4 = Father (widower) (1st claimant)
                                  E5 = Surviving divorced father (widower)
                                       (1st claimant)
                                  E6 = Father (widower) (2nd claimant)
                                  E7 = Mother (widow) (3rd claimant)
                                  E8 = Mother (widow) (4th claimant)
                                  E9 = Surviving divorced father (widower)
                                       (2nd claimant)
                                  EA = Mother (widow) (5th claimant)
                                  EB = Surviving divorced mother (3rd
                                       claimant)
                                  EC = Surviving divorced mother (4th
                                       claimant)
                                  ED = Surviving divorced mother (5th
                                       claimant
                                  EF = Father (widower) (3rd claimant)
                                  EG = Father (widower) (4th claimant)
                                  EH = Father (widower) (5th claimant)
                                  EJ = Surviving divorced father (3rd
```

```
                                claimant)
                EK = Surviving divorced father (4th
                     claimant)
                EM = Surviving divorced father (5th
                     claimant)
                F1 = Father
                F2 = Mother
                F3 = Stepfather
                F4 = Stepmother
                F5 = Adopting father
                F6 = Adopting mother
                F7 = Second alleged father
                F8 = Second alleged mother
                J1 = Primary prouty entitled to HIB
                     (less than 3 Q.C.) (general fund)
                J2 = Primary prouty entitled to HIB
                     (over 2 Q.C.) (RSI trust fund)
                J3 = Primary prouty not entitled to HIB
                     (less than 3 Q.C.) (general fund)
```

1   BENE_IDENT_TB   Beneficiary Identification Code (BIC) Table
         -------------   --

```
                J4 = Primary prouty not entitled to HIB
                     (over 2 Q.C.) (RSI trust fund)
                K1 = Prouty wife entitled to HIB (less than
                     3 Q.C.) (general fund) (1st claimant)
                K2 = Prouty wife entitled to HIB (over 2
                     Q.C.) (RSI trust fund) (1st claimant)
                K3 = Prouty wife not entitled to HIB (less
                     than 3 Q.C.) (general fund) (1st
                     claimant)
                K4 = Prouty wife not entitled to HIB (over
                     2 Q.C.) (RSI trust fund) (1st
                     claimant)
                K5 = Prouty wife entitled to HIB (less than
                     3 Q.C.) (general fund) (2nd claimant)
                K6 = Prouty wife entitled to HIB (over 2
                     Q.C.) (RSI trust fund) (2nd claimant)
                K7 = Prouty wife not entitled to HIB (less
                     than 3 Q.C.) (general fund) (2nd
                     claimant)
                K8 = Prouty wife not entitled to HIB (over
                     2 Q.C.) (RSI trust fund) (2nd
                     claimant)
                K9 = Prouty wife entitled to HIB (less than
                     3 Q.C.) (general fund) (3rd claimant)
                KA = Prouty wife entitled to HIB (over 2
                     Q.C.) (RSI trust fund) (3rd claimant)
```

```
            KB = Prouty wife not entitled to HIB (less
                 than 3 Q.C.) (general fund) (3rd
                 claimant)
            KC = Prouty wife not entitled to HIB (over
                 2 Q.C.) (RSI trust fund) (3rd
                 claimant)
            KD = Prouty wife entitled to HIB (less than
                 3 Q.C.) (general fund) (4th claimant)
            KE = Prouty wife entitled to HIB (over 2 Q.C
                 (4th claimant)
            KF = Prouty wife not entitled to HIB (less
                 than 3 Q.C.)(4th claimant)
            KG = Prouty wife not entitled to HIB (over
                 2 Q.C.)(4th claimant)
            KH = Prouty wife entitled to HIB (less than
                 3 Q.C.)(5th claimant)
            KJ = Prouty wife entitled to HIB (over 2
                 Q.C.) (5th claimant)
            KL = Prouty wife not entitled to HIB (less
                 than 3 Q.C.)(5th claimant)
            KM = Prouty wife not entitled to HIB (over
                 2 Q.C.) (5th claimant)
            M  = Uninsured-not qualified for deemed HIB
            M1 = Uninsured-qualified but refused HIB
            T  = Uninsured-entitled to HIB under deemed
                 or renal provisions
            TA = MQGE (primary claimant)
            TB = MQGE aged spouse (first claimant)
            TC = MQGE disabled adult child (first claimant)
            TD = MQGE aged widow(er) (first claimant)
            TE = MQGE young widow(er) (first claimant)
            TF = MQGE parent (male)
```

```
1      BENE_IDENT_TB              Beneficiary Identification Code (BIC) Table
       -------------              -------------------------------------------
```

```
            TG = MQGE aged spouse (second claimant)
            TH = MQGE aged spouse (third claimant)
            TJ = MQGE aged spouse (fourth claimant)
            TK = MQGE aged spouse (fifth claimant)
            TL = MQGE aged widow(er) (second claimant)
            TM = MQGE aged widow(er) (third claimant)
            TN = MQGE aged widow(er) (fourth claimant)
            TP = MQGE aged widow(er) (fifth claimant)
            TQ = MQGE parent (female)
            TR = MQGE young widow(er) (second claimant)
            TS = MQGE young widow(er) (third claimant)
            TT = MQGE young widow(er) (fourth claimant)
            TU = MQGE young widow(er) (fifth claimant)
```

```
       TV = MQGE disabled widow(er) fifth claimant
       TW = MQGE disabled widow(er) first claimant
       TX = MQGE disabled widow(er) second claimant
       TY = MQGE disabled widow(er) third claimant
       TZ = MQGE disabled widow(er) fourth claimant
       T2-T9 = Disabled child (second to ninth
               claimant)
       W  = Disabled widow, age 50 or over (1st
            claimant)
       W1 = Disabled widower, age 50 or over (1st
            claimant)
       W2 = Disabled widow (2nd claimant)
       W3 = Disabled widower (2nd claimant)
       W4 = Disabled widow (3rd claimant)
       W5 = Disabled widower (3rd claimant)
       W6 = Disabled surviving divorced wife (1st
            claimant)
       W7 = Disabled surviving divorced wife (2nd
            claimant)
       W8 = Disabled surviving divorced wife (3rd
            claimant)
       W9 = Disabled widow (4th claimant)
       WB = Disabled widower (4th claimant)
       WC = Disabled surviving divorced wife (4th
            claimant)
       WF = Disabled widow (5th claimant)
       WG = Disabled widower (5th claimant)
       WJ = Disabled surviving divorced wife (5th
            claimant)
       WR = Disabled surviving divorced husband
            (1st claimant)
       WT = Disabled surviving divorced husband
            (2nd claimant)

    Railroad Retirement Board:

       NOTE:
       Employee:  a Medicare beneficiary who is
                  still working or a worker who
                  died before retirement
       Annuitant: a person who retired under the
                  railroad retirement act on or
                  after 03/01/37
```
1	BENE_IDENT_TB	Beneficiary Identification Code (BIC) Table

```
       Pensioner: a person who retired prior to
                  03/01/37 and was included in the
```

railroad retirement act

```
          10 = Retirement - employee or annuitant
          80 = RR pensioner (age or disability)
          14 = Spouse of RR employee or annuitant
               (husband or wife)
          84 = Spouse of RR pensioner
          43 = Child of RR employee
          13 = Child of RR annuitant
          17 = Disabled adult child of RR annuitant
          46 = Widow/widower of RR employee
          16 = Widow/widower of RR annuitant
          86 = Widow/widower of RR pensioner
          43 = Widow of employee with a child in her care
          13 = Widow of annuitant with a child in her care
          83 = Widow of pensioner with a child in her care
          45 = Parent of employee
          15 = Parent of annuitant
          85 = Parent of pensioner
          11 = Survivor joint annuitant
               (reduced benefits taken to insure benefits
               for surviving spouse)
```

1   BENE_PRMRY_PYR_TB   Beneficiary Primary Payer Table
       -----------------   ------------------------------


```
          A = Working aged bene/spouse with employer
              group health plan (EGHP)
          B = End stage renal disease (ESRD) beneficiary
              in the 18 month coordination period with
              an employer group health plan
          C = Conditional payment by Medicare; future
              reimbursement expected
          D = Automobile no-fault (eff. 4/97; Prior
              to 3/94, also included any liability
              insurance)
          E = Workers' compensation
          F = Public Health Service or other federal
              agency (other than Dept. of Veterans
              Affairs)
          G = Working disabled bene (under age 65
              with LGHP)
          H = Black Lung
          I = Dept. of Veterans Affairs
          J = Any liability insurance
              (eff. 3/94 - 3/97)
          L = Any liability insurance (eff. 4/97)
```

                    (eff. 12/90 for carrier claims and 10/93
                    for FI claims; obsoleted for all claim
                    types 7/1/96)

          M = Override code: EGHP services involved
                    (eff. 12/90 for carrier claims and 10/93
                    for FI claims; obsoleted for all claim
                    types 7/1/96)

          N = Override code: non-EGHP services involved
                    (eff. 12/90 for carrier claims and 10/93
                    for FI claims; obsoleted for all claim
                    types 7/1/96)

          BLANK = Medicare is primary payer (not sure
                    of effective date: in use 1/91, if
                    not earlier)

          T = MSP cost avoided - IEQ contractor
                (eff. 7/96 carrier claims only)
          U = MSP cost avoided - HMO rate cell adjust-
                ment contractor (eff. 7/96 carrier claims
                only)
          V = MSP cost avoided - litigation settlement
                contractor (eff. 7/96 carrier claims
                only)

          X = MSP cost avoided override code (eff.
                12/90 for carrier claims and 10/93 for
                FI claims; obsoleted for all claim types
                7/1/96)

                    Prior to 12/90

          Y = Other secondary payer investigation
                shows Medicare as primary payer

1   BENE_PRMRY_PYR_TB   Beneficiary Primary Payer Table
      ------------------   ------------------------------

          Z = Medicare is primary payer

          NOTE: Values C, M, N, Y, Z and BLANK
                  indicate Medicare is primary payer.
                  (values Z and Y were used prior to
                  12/90. BLANK was suppose to be
                  effective after 12/90, but may have
                  been used prior to that date.)

                                    Page 95

1   BETOS_TB   BETOS Table
           --------   -----------

                         M1A = Office visits - new
                         M1B = Office visits - established
                         M2A = Hospital visit - initial
                         M2B = Hospital visit - subsequent
                         M2C = Hospital visit - critical care
                         M3 = Emergency room visit
                         M4A = Home visit
                         M4B = Nursing home visit
                         M5A = Specialist - pathology
                         M5B = Specialist - psychiatry
                         M5C = Specialist - opthamology
                         M5D = Specialist - other
                         M6 = Consultations
                         P0 = Anesthesia
                         P1A = Major procedure - breast
                         P1B = Major procedure - colectomy
                         P1C = Major procedure - cholecystectomy
                         P1D = Major procedure - turp
                         P1E = Major procedure - hysterctomy
                         P1F = Major procedure - explor/decompr/excisdisc
                         P1G = Major procedure - Other
                         P2A = Major procedure, cardiovascular-CABG
                         P2B = Major procedure, cardiovascular-Aneurysm repair
                         P2C = Major Procedure, cardiovascular-Thromboendarterectomy
                         P2D = Major procedure, cardiovascualr-Coronary angioplasty (PTCA)
                         P2E = Major procedure, cardiovascular-Pacemaker insertion
                         P2F = Major procedure, cardiovascular-Other
                         P3A = Major procedure, orthopedic - Hip fracture repair
                         P3B = Major procedure, orthopedic - Hip replacement
                         P3C = Major procedure, orthopedic - Knee replacement
                         P3D = Major procedure, orthopedic - other
                         P4A = Eye procedure - corneal transplant
                         P4B = Eye procedure - cataract removal/lens insertion
                         P4C = Eye procedure - retinal detachment
                         P4D = Eye procedure - treatment
                         P4E = Eye procedure - other
                         P5A = Ambulatory procedures - skin
                         P5B = Ambulatory procedures - musculoskeletal
                         P5C = Ambulatory procedures - inguinal hernia repair
                         P5D = Ambulatory procedures - lithotripsy
                         P5E = Ambulatory procedures - other
                         P6A = Minor procedures - skin
                         P6B = Minor procedures - musculoskeletal
                         P6C = Minor procedures - other (Medicare fee schedule)

```
                          P6D = Minor procedures - other (non-Medicare fee schedule)
                          P7A = Oncology - radiation therapy
                          P7B = Oncology - other
                          P8A = Endoscopy - arthroscopy
                          P8B = Endoscopy - upper gastrointestinal
                          P8C = Endoscopy - sigmoidoscopy
                          P8D = Endoscopy - colonoscopy
                          P8E = Endoscopy - cystoscopy
                          P8F = Endoscopy - bronchoscopy
                          P8G = Endoscopy - laparoscopic cholecystectomy
                          P8H = Endoscopy - laryngoscopy
                          P8I = Endoscopy - other
                          P9A = Dialysis services
1          BETOS_TB                            BETOS Table
           --------                            -----------

                          I1A = Standard imaging - chest
                          I1B = Standard imaging - musculoskeletal
                          I1C = Standard imaging - breast
                          I1D = Standard imaging - contrast gastrointestinal
                          I1E = Standard imaging - nuclear medicine
                          I1F = Standard imaging - other
                          I2A = Advanced imaging - CAT: head
                          I2B = Advanced imaging - CAT: other
                          I2C = Advanced imaging - MRI: brain
                          I2D = Advanced imaging - MRI: other
                          I3A = Echography - eye
                          I3B = Echography - abdomen/pelvis
                          I3C = Echography - heart
                          I3D = Echography - carotid arteries
                          I3E = Echography - prostate, transrectal
                          I3F = Echography - other
                          I4A = Imaging/procedure - heart including cardiac
                                            catheter
                          I4B = Imaging/procedure - other
                          T1A = Lab tests - routine venipuncture (non Medicare
                                            fee schedule)
                          T1B = Lab tests - automated general profiles
                          T1C = Lab tests - urinalysis
                          T1D = Lab tests - blood counts
                          T1E = Lab tests - glucose
                          T1F = Lab tests - bacterial cultures
                          T1G = Lab tests - other (Medicare fee schedule)
                          T1H = Lab tests - other (non-Medicare fee schedule)
                          T2A = Other tests - electrocardiograms
                          T2B = Other tests - cardiovascular stress tests
                          T2C = Other tests - EKG monitoring
                          T2D = Other tests - other
```

```
                         D1A = Medical/surgical supplies
                         D1B = Hospital beds
                         D1C = Oxygen and supplies
                         D1D = Wheelchairs
                         D1E = Other DME
                         D1F = Orthotic devices
                         O1A = Ambulance
                         O1B = Chiropractic
                         O1C = Enteral and parenteral
                         O1D = Chemotherapy
                         O1E = Other drugs
                         O1F = Vision, hearing and speech services
                         O1G = Influenza immunization
                         Y1  = Other - Medicare fee schedule
                         Y2  = Other - non-Medicare fee schedule
                         Z1  = Local codes
                         Z2  = Undefined codes
```

```
1     CARR_CLM_PMT_DNL_TB                        Carrier Claim Payment Denial Table
      -------------------                        ----------------------------------
```

```
                         0 = Denied
                         1 = Physician/supplier
                         2 = Beneficiary
                         3 = Both physician/supplier and beneficiary
                         4 = Hospital (hospital based physicians)
                         5 = Both hospital and beneficiary
                         6 = Group practice prepayment plan
                         7 = Other entries (e.g. Employer, union)
                         8 = Federally funded
                         9 = PA service
                         A = Beneficiary under limitation of
                             liability
                         B = Physician/supplier under limitation of
                             liability
                         D = Denied due to demonstration involvement
                             (eff. 5/97)
                         E = MSP cost avoided IRS/SSA/HCFA Data
                             Match (eff. 7/3/00)
                         F = MSP cost avoided HMO Rate Cell
                             (eff. 7/3/00)
                         G = MSP cost avoided Litigation Settlement
                             (eff. 7/3/00)
                         H = MSP cost avoided Employer Voluntary
                             Reporting (eff. 7/3/00)
                         J = MSP cost avoided Insurer Voluntary
                             Reporting (eff. 7/3/00)
```

```
        K = MSP cost avoided Initial Enrollment
            Questionnaire (eff. 7/3/00)
        P = Physician ownership denial (eff 3/92)
        Q = MSP cost avoided - (Contractor #88888)
            voluntary agreement (eff. 1/98)
        T = MSP cost avoided - IEQ contractor
            (eff. 7/96) (obsolete 6/30/00)
        U = MSP cost avoided - HMO rate cell
            adjustment (eff. 7/96) (obsolete 6/30/00)
        V = MSP cost avoided - litigation
            settlement (eff. 7/96) (obsolete 6/30/00)
        X = MSP cost avoided - generic
        Y = MSP cost avoided - IRS/SSA data
            match project (obsolete 6/30/00)
```

```
1   CARR_LINE_PRVDR_TYPE_TB                    Carrier Line Provider Type Table
    ------------------------                   --------------------------------
```

```
        For Physician/Supplier (RIC O) Claims:

        0 = Clinics, groups, associations,
            partnerships, or other entities
        1 = Physicians or suppliers reporting as
            solo practitioners
        2 = Suppliers (other than sole proprietorship)
        3 = Institutional provider
        4 = Independent laboratories
        5 = Clinics (multiple specialties)
        6 = Groups (single specialty)
        7 = Other entities

        For DMERC (RIC M) Claims - PRIOR TO VERSION H:

        0 = Clinics, groups, associations,
            partnerships, or other entities
            for whom the carrier's own ID number
            has been assigned.
        1 = Physicians or suppliers billing as
            solo practitioners for whom SSN's are
            shown in the physician ID code field.
        2 = Physicians or suppliers billing as
            solo practitioners for whom the carrier's
            own physician ID code is shown.
        3 = Suppliers (other than sole proprietorship)
            for whom EI numbers are used in coding the
            ID field.
        4 = Suppliers (other than sole proprietorship)
```

for whom the carrier's own code has been
shown.
5 = Institutional providers and
    independent laboratories for whom EI
    numbers are used in coding the ID field.
6 = Institutional providers and
    independent laboratories for whom the
    carrier's own ID number is shown.
7 = Clinics, groups, associations, or
    partnerships for whom EI numbers
    are used in coding the ID field.
8 = Other entities for whom EI numbers
    are used in coding the ID field or
    proprietorship for whom EI numbers are
    used in coding the ID field.

1CARR_LINE_RDCD_PHYSN_ASTNT_TB   Carrier Line Part B Reduced Physician Assistant Table
------------------------------   ---

BLANK = Adjustment situation (where
        CLM_DISP_CD equal 3)
0 = N/A
1 = 65%
    A) Physician assistants assisting in
       surgery
    B) Nurse midwives
2 = 75%
    A) Physician assistants performing
       services in a hospital (other than
       assisting surgery)
    B) Nurse practitioners and clinical
       nurse specialists performing
       services in rural areas
    C) Clinical social worker services
3 = 85%
    A) Physician assistant services for
       other than assisting surgery
    B) Nurse practitioners services

1   CARR_NUM_TB   Carrier Number Table
        -----------   --------------------

00510 = Alabama BS (eff. 1983)
00511 = Georgia - Alabama BS (eff. 1998)
00512 = Mississippi - Alabama BS (eff. 2000)
00520 = Arkansas BS (eff. 1983)

```
00521 = New Mexico - Arkansas BS (eff. 1998)
00522 = Oklahoma - Arkansas BS (eff. 1998)
00523 = Missouri - Arkansas BS (eff. 1999)
00528 = Louisianna - Arkansas BS (eff. 1984)
00542 = California BS (eff. 1983; term. 1996)
00550 = Colorado BS (eff. 1983; term. 1994)
00570 = Delaware - Pennsylvania BS (eff. 1983;
          term. 1997)
00580 = District of Columbia - Pennsylvania BS
          (eff. 1983; term. 1997)
00590 = Florida BS (eff. 1983)
00591 = Connecticut - Florida BS (eff. 2000)
00621 = Illinois BS - HCSC (eff. 1983; term. 1998)
00623 = Michigan - Illinois Blue Shield (eff. 1995)
          (term. 1998)
00630 = Indiana - Administar (eff. 1983)
00635 = DMERC-B (Administar Federal, Inc.)
          (eff. 1993)
00640 = Iowa - Wellmark, Inc. (eff. 1983; term. 1998)
00645 = Nebraska - Iowa BS (eff. 1985; term. 1987)
00650 = Kansas BS (eff. 1983)
00655 = Nebraska - Kansas BS (eff. 1988)
00660 = Kentucky - Administar (eff. 1983)
00690 = Maryland BS (eff. 1983; term. 1994)
00700 = Massachusetts BS (eff. 1983; term. 1997)
00710 = Michigan BS (eff. 1983; term. 1994)
00720 = Minnesota BS (eff. 1983; term. 1995)
00740 = Missouri - BS Kansas City (eff. 1983)
00751 = Montana BS (eff. 1983)
00770 = New Hampshire/Vermont Physician Services
          (eff. 1983; term. 1984)
00780 = New Hampshire/Vermont - Massachusetts BS
          (eff. 1985; term. 1997)
00801 = New York - Western BS (eff. 1983)
00803 = New York - Empire BS (eff. 1983)
00805 = New Jersey - Empire BS (eff. 3/99)
00811 = DMERC (A) - Western New York BS (eff. 2000)
00820 = North Dakota - North Dakota BS (eff. 1983)
00824 = Colorado - North Dakota BS (eff. 1995)
00825 = Wyoming - North Dakota BS (eff. 1990)
00826 = Iowa - North Dakota BS (eff. 1999)
00831 = Alaska - North Dakota BS (eff. 1998)
00832 = Arizona -  North Dakota BS (eff. 1998)
00833 = Hawaii - North Dakota BS (eff. 1998)
00834 = Nevada - North Dakota BS (eff. 1998)
00835 = Oregon - North Dakota BS (eff. 1998)
00836 = Washington - North Dakota BS (eff. 1998)
00860 = New Jersey - Pennsylvania BS (eff. 1988;
```

```
                                    term. 1999)
                        00865 = Pennsylvania BS (eff. 1983)
                        00870 = Rhode Island BS (eff. 1983)
                        00880 = South Carolina BS (eff. 1983)
                        00882 = RRB - South Carolina PGBA (eff. 2000)
1          CARR_NUM_TB                        Carrier Number Table
           -----------                        --------------------

                        00885 = DMERC C - Palmetto (eff. 1993)
                        00900 = Texas BS (eff. 1983)
                        00901 = Maryland - Texas BS (eff. 1995)
                        00902 = Delaware - Texas BS (eff. 1998)
                        00903 = District of Columbia - Texas BS (eff. 1998)
                        00904 = Virginia - Texas BS (eff. 2000)
                        00910 = Utah  BS (eff. 1983)
                        00951 = Wisconsin - Wisconsin Phy Svc (eff. 1983)
                        00952 = Illinois - Wisconsin Phy Svc (eff. 1999)
                        00953 = Michigan - Wisconsin Phy Svc (eff. 1999)
                        00954 = Minnesota - Wisconsin Phy Svc (eff. 2000)
                        00973 = Triple-S, Inc. - Puerto Rico (eff. 1983)
                        00974 = Triple-S, Inc. - Virgin Islands
                        01020 = Alaska - AETNA (eff. 1983; term. 1997)
                        01030 = Arizona - AETNA (eff. 1983; term. 1997)
                        01040 = Georgia - AETNA (eff. 1988; term. 1997)
                        01120 = Hawaii - AETNA (eff. 1983; term. 1997)
                        01290 = Nevada - AETNA (eff. 1983; term. 1997)
                        01360 = New Mexico - AETNA (eff. 1986; term. 1997)
                        01370 = Oklahoma - AETNA (eff. 1983; term. 1997)
                        01380 = Oregon - AETNA (eff. 1983; term. 1997
                        01390 = Washington - AETNA (eff. 1994; term. 1997)
                        02050 = California - TOLIC (eff. 1983)
                                (term. 2000)
                        03070 = Connecticut General Life Insurance Co.
                                (eff. 1983; term. 1985)
                        05130 = Idaho - Connecticut General (eff. 1983)
                        05320 = New Mexico - Equitable Insurance
                                (eff. 1983; term. 1985)
                        05440 = Tennessee - Connecticut General (eff. 1983)
                        05530 = Wyoming - Equitable Insurance (eff. 1983)
                                (term. 1989)
                        05535 = North Carolina - Connecticut General
                                (eff. 1988)
                        05655 = DMERC-D - Connecticut General (eff. 1993)
                        10071 = Railroad Board Travelers (eff. 1983)
                                (term. 2000)
                        10230 = Connecticut - Metra Health (eff. 1986)
                                (term. 2000)
                        10240 = Minnesota - Metra Health (eff. 1983)
```

```
                      (term. 2000)
          10250 = Mississippi - Metra Health (eff. 1983)
                      (term. 2000)
          10490 = Virginia - Metra Health (eff. 1983)
                      (term. 2000)
          10555 = Travelers Insurance Co. (eff. 1993)
                      (term. 2000)
          11260 = Missouri - General American Life
                      (eff. 1983; term. 1998)
          14330 = New York - GHI (eff. 1983)
          16360 = Ohio - Nationwide Insurance Co.
          16510 = West Virginia - Nationwide Insurance Co.
          21200 = Maine - BS of Massachusetts
          31140 = California - National Heritage Ins.
          31142 = Maine - National Heritage Ins.
          31143 = Massachusetts - National Heritage Ins.
          31144 = New Hampshire - National Heritage Ins.
          31145 = Vermont - National Heritage Ins.
```

1   CARR_NUM_TB   Carrier Number Table
            -----------   --------------------

```
          31146 = So. California - NHIC (eff. 2000)
```

1   CLM_DISP_TB   Claim Disposition Table
            -----------   -----------------------

```
          01 = Debit accepted
          02 = Debit accepted (automatic adjustment)
               applicable through 4/4/93
          03 = Cancel accepted
          61 = *Conversion code: debit accepted
          62 = *Conversion code: debit accepted
               (automatic adjustment)
          63 = *Conversion code: cancel accepted

             *Used only during conversion period:
                1/1/91 - 2/21/91
```

1 CTGRY_EQTBL_BENE_IDENT_TB   Category Equatable Beneficiary Identification Code (BIC) Table
   -------------------------   ---

```
          NCH BIC              SSA Categories
          -------              --------------

          A  = A;J1;J2;J3;J4;M;M1;T;TA
          B  = B;B2;B6;D;D4;D6;E;E1;K1;K2;K3;K4;W;W6;
```

```
        TB(F);TD(F);TE(F);TW(F)
B1 = B1;BR;BY;D1;D5;DC;E4;E5;W1;WR;TB(M)
        TD(M);TE(M);TW(M)
B3 = B3;B5;B9;D2;D7;D9;E2;E3;K5;K6;K7;K8;W2
        W7;TG(F);TL(F);TR(F);TX(F)
B4 = B4;BT;BW;D3;DM;DP;E6;E9;W3;WT;TG(M)
        TL(M);TR(M);TX(M)
B8 = B8;B7;BN;D8;DA;DV;E7;EB;K9;KA;KB;KC;W4
        W8;TH(F);TM(F);TS(F);TY(F)
BA = BA;BK;BP;DD;DL;DW;E8;EC;KD;KE;KF;KG;W9
        WC;TJ(F);TN(F);TT(F);TZ(F)
BD = BD;BL;BQ;DG;DN;DY;EA;ED;KH;KJ;KL;KM;WF
        WJ;TK(F);TP(F);TU(F);TV(F)
BG = BG;DH;DQ;DS;EF;EJ;W5;TH(M);TM(M);TS(M)
        TY(M)
BH = BH;DJ;DR;DX;EG;EK;WB;TJ(M);TN(M);TT(M)
        TZ(M)
BJ = BJ;DK;DT;DZ;EH;EM;WG;TK(M);TP(M);TU(M)
        TV(M)
C1 = C1;TC
C2 = C2;T2
C3 = C3;T3
C4 = C4;T4
C5 = C5;T5
C6 = C6;T6
C7 = C7;T7
C8 = C8;T8
C9 = C9;T9
F1 = F1;TF
F2 = F2;TQ
F3-F8 = Equatable only to itself (e.g., F3 IS
        equatable to F3)
CA-CZ = Equatable only to itself.  (e.g., CA is
        only equatable to CA)


        ---------------------------------------
                    RRB Categories


10 = 10
11 = 11
13 = 13;17
14 = 14;16
15 = 15
43 = 43
45 = 45
46 = 46
80 = 80
83 = 83
```

```
                                               84 = 84;86
                                               85 = 85
```

1   GEO_SSA_STATE_TB   State Table
        ----------------   -----------

                                    01 = Alabama
                                    02 = Alaska
                                    03 = Arizona
                                    04 = Arkansas
                                    05 = California
                                    06 = Colorado
                                    07 = Connecticut
                                    08 = Delaware
                                    09 = District of Columbia
                                    10 = Florida
                                    11 = Georgia
                                    12 = Hawaii
                                    13 = Idaho
                                    14 = Illinois
                                    15 = Indiana
                                    16 = Iowa
                                    17 = Kansas
                                    18 = Kentucky
                                    19 = Louisiana
                                    20 = Maine
                                    21 = Maryland
                                    22 = Massachusetts
                                    23 = Michigan
                                    24 = Minnesota
                                    25 = Mississippi
                                    26 = Missouri
                                    27 = Montana
                                    28 = Nebraska
                                    29 = Nevada
                                    30 = New Hampshire
                                    31 = New Jersey
                                    32 = New Mexico
                                    33 = New York
                                    34 = North Carolina
                                    35 = North Dakota
                                    36 = Ohio
                                    37 = Oklahoma
                                    38 = Oregon
                                    39 = Pennsylvania
                                    40 = Puerto Rico
                                    41 = Rhode Island

```

```
                              42 = South Carolina
                              43 = South Dakota
                              44 = Tennessee
                              45 = Texas
                              46 = Utah
                              47 = Vermont
                              48 = Virgin Islands
                              49 = Virginia
                              50 = Washington
                              51 = West Virginia
                              52 = Wisconsin
                              53 = Wyoming
                              54 = Africa
                              55 = Asia
                              56 = Canada & Islands
                              57 = Central America and West Indies
```

1     GEO_SSA_STATE_TB                                 State Table
      ----------------                                 -----------

```
                              58 = Europe
                              59 = Mexico
                              60 = Oceania
                              61 = Philippines
                              62 = South America
                              63 = U.S. Possessions
                              64 = American Samoa
                              65 = Guam
                              66 = Saipan
                              97 = Northern Marianas
                              98 = Guam
                              99 = With 000 county code is American Samoa;
                                   otherwise unknown
```

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
     --------------------   -----------------------------

                              Prior to 5/92

```
                 01 = General practice
                 02 = General surgery
                 03 = Allergy (revised 10/91 to mean allergy/
                      immunology)
                 04 = Otology, laryngology, rhinology
                      revised 10/91 to mean otolaryngology)
                 05 = Anesthesiology
                 06 = Cardiovascular disease (revised 10/91
                      to mean cardiology)
```

```
07 = Dermatology
08 = Family practice
09 = Gynecology--osteopaths only (deleted
     10/91; changed to '16')
10 = Gastroenterology
11 = Internal medicine
12 = Manipulative therapy (osteopaths only)
     (revised 10/91 to mean osteopathic
     manipulative therapy)
13 = Neurology
14 = Neurological surgery (revised 10/91 to
     mean neurosurgery)
15 = Obstetrics--osteopaths only (deleted
     10/91; changed to '16')
16 = OB-gynecology
17 = Ophthalmology, otology, laryngology
     rhinology--osteopaths only (deleted
     10/91; changed to '18' if physicians
     practice is more than 50% ophthalmology
     or to '04' if physician's practice is
     more than 50% otolaryngology.  If
     practice is 50/50, choose specialty
     with greater allowed charges.
18 = Ophthalmology
19 = Oral surgery (dentists only)
20 = Orthopedic surgery
21 = Pathologic anatomy, clinical pathology-
     osteopaths only (deleted 10/91;
     changed to '22')
22 = Pathology
23 = Peripheral vascular disease or surgery
     (deleted 10/91; changed to '76')
24 = Plastic surgery (revised to mean
     plastic and reconstructive surgery).
25 = Physical medicine and rehabilitation
26 = Psychiatry
27 = Psychiatry, neurology (osteopaths only)
     (deleted 10/91; changed to '86')
28 = Proctology (revised 10/91 to mean
     colorectal surgery).
29 = Pulmonary disease
30 = Radiology (revised 10/91 to mean
     diagnostic radiology)
31 = Roentgenology, radiology (osteopaths)
     (deleted 10/91; changed to '30')
32 = Radiation therapy--osteopaths (deleted
```

        10/91; changed to '92')
33 = Thoracic surgery
34 = Urology
35 = Chiropractor, licensed (revised 10/91
     to mean chiropractic)
36 = Nuclear medicine
37 = Pediatrics (revised 10/91 to mean
     pediatric medicine)
38 = Geriatrics (revised 10/91 to mean
     geriatric medicine)
39 = Nephrology
40 = Hand surgery
41 = Optometrist - services related to
     condition of aphakia (revised 10/91 to
     mean optometrist)
42 = Certified nurse midwife (added 7/88)
43 = Certified registered nurse anesthetist
     (revised 10/91 to mean CRNA,
     anesthesia assistant)
44 = Infectious disease
46 = Endocrinology (added 10/91)
48 = Podiatry - surgery chiropody (revised
     10/91 to mean podiatry)
49 = Miscellaneous (include ASCS)
51 = Medical supply company with C.O.
     certification (certified orthotist -
     certified by American Board for
     Certification in Prosthetics and
     Orthotics.
52 = Medical supply company with C.P.
     certification (certified prosthetist -
     certified by American Board for
     Certification in Prosthetics and Orthotics).
53 = Medical supply company with C.P.O.
     certification (certified prosthetist -
     orthotist - certified by American
     Board for Certification in Prosthetics
     and Orthotics).
54 = Medical supply company not included in
     51, 52, or 53.
55 = Individual certified orthotist
56 = Individual certified prosthetist
57 = Individual certified prosthetist -
     orthotist
58 = Individuals not included in 55,56 or 57
59 = Ambulance service supplier (e.g.
     private ambulance companies, funeral

```
                            homes, etc.)
                       60 = Public health or welfare agencies
                            (federal, state, and local)
                       61 = Voluntary health or charitable agencies
                            (e.g. National Cancer Society, National
                            Heart Association, Catholic Charities)
                       62 = Psychologist--billing independently
                       63 = Portable X-ray supplier--billing
                            independently (revised 10/91 to mean
                            portable X-ray supplier)
                       64 = Audiologist (billing independently)
```

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
         -------------------   ----------------------------

```
                       65 = Physical therapist (independent practice)
                       66 = Rheumatology (added 10/91)
                       67 = Occupational therapist--independent
                            practice
                       68 = Clinical psychologist
                       69 = Independent laboratory--billing
                            independently (revised 10/91 to mean
                            independent clinical laboratory --
                            billing independently)
                       70 = Clinic or other group practice, except
                            Group Practice Prepayment Plan (GPPP)
                       71 = Group Practice Prepayment Plan - diagnostic
                            X-ray (do not use after 1/92)
                       72 = Group Practice Prepayment Plan - diagnostic
                            laboratory (do not use after 1/92)
                       73 = Group Practice Prepayment Plan -
                            physiotherapy (do not use after 1/92)
                       74 = Group Practice Prepayment Plan - occupational
                            therapy (do not use after 1/92)
                       75 = Group Practice Prepayment Plan - other
                            medical care (do not use after 1/92)
                       76 = Peripheral vascular disease
                            (added 10/91)
                       77 = Vascular surgery (added 10/91)
                       78 = Cardiac surgery (added 10/91)
                       79 = Addiction medicine (added 10/91)
                       80 = Clinical social worker (1991)
                       81 = Critical care-intensivists (added 10/91)
                       82 = Ophthalmology, cataracts specialty
                            (added 10/91; used only until 5/92)
                       83 = Hematology/oncology (added 10/91)
                       84 = Preventive medicine (added 10/91)
                       85 = Maxillofacial surgery (added 10/91)
                       86 = Neuropsychiatry (added 10/91)
```

```
              87 = All other (e.g. drug and department
                   stores) (revised 10/91 to mean all
                   other suppliers)
              88 = Unknown (revised 10/91 to mean
                   physician assistant)
              90 = Medical oncology (added 10/91)
              91 = Surgical oncology (added 10/91)
              92 = Radiation oncology (added 10/91)
              93 = Emergency medicine (added 10/91)
              94 = Interventional radiology (added 10/91)
              95 = Independent physiological laboratory
                   (added 10/91)
              96 = Unknown physician specialty
                   (added 10/91)
              99 = Unknown--incl. social worker's
                   psychiatric services (revised 10/91 to
                   mean unknown supplier/provider)
                   ----------------------------------------
                         **Effective 5/92**

              00 = Carrier wide
              01 = General practice
              02 = General surgery
              03 = Allergy/immunology
```

```
1    HCFA_PRVDR_SPCLTY_TB                 HCFA Provider Specialty Table
     --------------------                 ----------------------------
```

```
              04 = Otolaryngology
              05 = Anesthesiology
              06 = Cardiology
              07 = Dermatology
              08 = Family practice
              09 = Gynecology (osteopaths only)
                   (discontinued 5/92 use code 16)
              10 = Gastroenterology
              11 = Internal medicine
              12 = Osteopathic manipulative therapy
              13 = Neurology
              14 = Neurosurgery
              15 = Obstetrics (osteopaths only)
                   (discontinued 5/92 use code 16)
              16 = Obstetrics/gynecology
              17 = Ophthalmology, otology, laryngology,
                   rhinology (osteopaths only)
                   (discontinued 5/92 use codes 18 or 04
                   depending on percentage of practice)
              18 = Ophthalmology
              19 = Oral surgery (dentists only)
```

```
                              20 = Orthopedic surgery
                              21 = Pathologic anatomy, clinical
                                     pathology (osteopaths only)
                                     (discontinued 5/92 use code 22)
                              22 = Pathology
                              23 = Peripheral vascular disease, medical
                                     or surgical (osteopaths only)
                                     (discontinued 5/92 use code 76)
                              24 = Plastic and reconstructive surgery
                              25 = Physical medicine and rehabilitation
                              26 = Psychiatry
                              27 = Psychiatry, neurology (osteopaths
                                     only) (discontinued 5/92 use code 86)
                              28 = Colorectal surgery (formerly
                                     proctology)
                              29 = Pulmonary disease
                              30 = Diagnostic radiology
                              31 = Roentgenology, radiology (osteopaths
                                     only) (discontinued 5/92 use code 30)
                              32 = Radiation therapy (osteopaths only)
                                     (discontinued 5/92 use code 92)
                              33 = Thoracic surgery
                              34 = Urology
                              35 = Chiropractic
                              36 = Nuclear medicine
                              37 = Pediatric medicine
                              38 = Geriatric medicine
                              39 = Nephrology
                              40 = Hand surgery
                              41 = Optometry (revised 10/93 to
                                     mean optometrist)
                              42 = Certified nurse midwife (eff 1/87)
                              43 = Crna, anesthesia assistant
                                     (eff 1/87)
                              44 = Infectious disease
                              45 = Mammography screening center
                              46 = Endocrinology (eff 5/92)
```

```
1     HCFA_PRVDR_SPCLTY_TB                      HCFA Provider Specialty Table
      --------------------                      ----------------------------
```

```
                              47 = Independent Diagnostic Testing Facility
                                     (IDTF) (eff. 6/98)
                              48 = Podiatry
                              49 = Ambulatory surgical center
                                     (formerly miscellaneous)
                              50 = Nurse practitioner
                              51 = Medical supply company with
                                     certified orthotist (certified by
```

                American Board for Certification in
                Prosthetics And Orthotics)
    52 = Medical supply company with
                certified prosthetist
                (certified by American Board for
                Certification In Prosthetics And
                Orthotics)
    53 = Medical supply company with
                certified prosthetist-orthotist
                (certified by American Board for
                Certification in Prosthetics
                and Orthotics)
    54 = Medical supply company not included
                in 51, 52, or 53. (Revised 10/93
                to mean medical supply company for DMERC)
    55 = Individual certified orthotist
    56 = Individual certified prosthetist
    57 = Individual certified prosthetist-
                orthotist
    58 = Individuals not included in 55, 56,
                or 57 (revised 10/93 to mean medical
                supply company with registered
                pharmacist)
    59 = Ambulance service supplier, e.G.,
                private ambulance companies, funeral
                homes, etc.
    60 = Public health or welfare agencies
                (federal, state, and local)
    61 = Voluntary health or charitable
                agencies (e.G., National Cancer
                Society, National Heart Associiation,
                Catholic Charities)
    62 = Psychologist (billing independently)
    63 = Portable X-ray supplier
    64 = Audiologist (billing independently)
    65 = Physical therapist (independently
                practicing)
    66 = Rheumatology (eff 5/92)
                Note: during 93/94 DMERC also used this
                to mean medical supply company with
                respiratory therapist
    67 = Occupational therapist (independently
                practicing)
    68 = Clinical psychologist
    69 = Clinical laboratory (billing
                independently)
    70 = Multispecialty clinic or group
                practice

71 = Diagnostic X-ray (GPPP) (not to
     be assigned after 5/92)

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
       --------------------   ----------------------------

72 = Diagnostic laboratory (GPPP)
     (not to be assigned after 5/92)
73 = Physiotherapy (GPPP) (not to be
     assigned after 5/92)
74 = Occupational therapy (GPPP)
     (not to be assigned after 5/92)
75 = Other medical care (GPPP) (not to
     assigned after 5/92)
76 = Peripheral vascular disease
     (eff 5/92)
77 = Vascular surgery (eff 5/92)
78 = Cardiac surgery (eff 5/92)
79 = Addiction medicine (eff 5/92)
80 = Licensed clinical social worker
81 = Critical care (intensivists)
     (eff 5/92)
82 = Hematology (eff 5/92)
83 = Hematology/oncology (eff 5/92)
84 = Preventive medicine (eff 5/92)
85 = Maxillofacial surgery (eff 5/92)
86 = Neuropsychiatry (eff 5/92)
87 = All other suppliers (e.g. drug and
     department stores) (note: DMERC used
     87 to mean department store from 10/93
     through 9/94; recoded eff 10/94 to A7;
     NCH cross-walked DMERC reported 87 to A7.
88 = Unknown supplier/provider specialty
     (note: DMERC used 87 to mean grocery
     store from 10/93 - 9/94; recoded eff
     10/94 to A8; NCH cross-walked DMERC
     reported 88 to A8.
89 = Certified clinical nurse specialist
90 = Medical oncology (eff 5/92)
91 = Surgical oncology (eff 5/92)
92 = Radiation oncology (eff 5/92)
93 = Emergency medicine (eff 5/92)
94 = Interventional radiology (eff 5/92)
95 = Independent physiological
     laboratory (eff 5/92)
96 = Optician (eff 10/93)
97 = Physician assistant (eff 5/92)
98 = Gynecologist/oncologist (eff 10/94)
99 = Unknown physician specialty

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```
                                 A0 = Hospital (eff 10/93) (DMERCs only)
                                 A1 = SNF (eff 10/93) (DMERCs only)
                                 A2 = Intermediate care nursing facility
                                      (eff 10/93) (DMERCs only)
                                 A3 = Nursing facility, other (eff 10/93)
                                      (DMERCs only)
                                 A4 = HHA (eff 10/93) (DMERCs only)
                                 A5 = Pharmacy (eff 10/93) (DMERCs only)
                                 A6 = Medical supply company with respiratory
                                      therapist (eff 10/93) (DMERCs only)
                                 A7 = Department store (for DMERC use:
                                      eff 10/94, but cross-walked from
                                      code 87 eff 10/93)
                                 A8 = Grocery store (for DMERC use:
                                      eff 10/94, but cross-walked from
```

1   HCFA_PRVDR_SPCLTY_TB   HCFA Provider Specialty Table
     ---------------------   -----------------------------

```
                                 code 88 eff 10/93)
```

1   HCFA_TYPE_SRVC_TB   HCFA Type of Service Table
     -----------------   --------------------------

```
                                 1 = Medical care
                                 2 = Surgery
                                 3 = Consultation
                                 4 = Diagnostic radiology
                                 5 = Diagnostic laboratory
                                 6 = Therapeutic radiology
                                 7 = Anesthesia
                                 8 = Assistant at surgery
                                 9 = Other medical items or services
                                 0 = Whole blood only eff 01/96,
                                     whole blood or packed red cells before 01/96
                                 A = Used durable medical equipment (DME)
                                 B = High risk screening mammography
                                     (obsolete 1/1/98)
                                 C = Low risk screening mammography
                                     (obsolete 1/1/98)
                                 D = Ambulance (eff 04/95)
                                 E = Enteral/parenteral nutrients/supplies
                                     (eff 04/95)
                                 F = Ambulatory surgical center (facility
                                     usage for surgical services)
                                 G = Immunosuppressive drugs
                                 H = Hospice services (discontinued 01/95)
                                 I = Purchase of DME (installment basis)
```

```
                    (discontinued 04/95)
          J = Diabetic shoes (eff 04/95)
          K = Hearing items and services (eff 04/95)
          L = ESRD supplies (eff 04/95)
                    (renal supplier in the home before 04/95)
          M = Monthly capitation payment for dialysis
          N = Kidney donor
          P = Lump sum purchase of DME, prosthetics,
                    orthotics
          Q = Vision items or services
          R = Rental of DME
          S = Surgical dressings or other medical supplies
                    (eff 04/95)
          T = Psychological therapy (term. 12/31/97)
                    outpatient mental health limitation (eff. 1/1/98)
          U = Occupational therapy
          V = Pneumococcal/flu vaccine (eff 01/96),
                    Pneumococcal/flu/hepatitis B vaccine (eff 04/95-12/95),
                    Pneumococcal only before 04/95
          W = Physical therapy
          Y = Second opinion on elective surgery
                    (obsoleted 1/97)
          Z = Third opinion on elective surgery
                    (obsoleted 1/97)
```

1 LINE_ADDTNL_CLM_DCMTN_IND_TB   Line Additional Claim Documentation Indicator Table
  ---------------------------   ---

```
          0 = No additional documentation
          1 = Additional documentation submitted for
                    non-DME EMC claim
          2 = CMN/prescription/other documentation submitted
                    which justifies medical necessity
          3 = Prior authorization obtained and approved
          4 = Prior authorization requested but not approved
          5 = CMN/prescription/other documentation submitted
                    but did not justify medical necessity
          6 = CMN/prescription/other documentation submitted
                    and approved after prior authorization rejected
          7 = Recertification CMN/prescription/other
                    documentation
```

1   LINE_PLC_SRVC_TB   Line Place Of Service Table
        ----------------   ---------------------------

                              Prior To 1/92

```
1 = Office
2 = Home
3 = Inpatient hospital
4 = SNF
5 = Outpatient hospital
6 = Independent lab
7 = Other
8 = Independent kidney disease treatment
    center
9 = Ambulatory
A = Ambulance service
H = Hospice
M = Mental health, rural mental health
N = Nursing home
R = Rural codes

    ---------------------------------------
             **Effective 1/92**

11 = Office
12 = Home
21 = Inpatient hospital
22 = Outpatient hospital
23 = Emergency room - hospital
24 = Ambulatory surgical center
25 = Birthing center
26 = Military treatment facility
31 = Skilled nursing facility
32 = Nursing facility
33 = Custodial care facility
34 = Hospice
35 = Adult living care facilities (ALCF)
     (eff. NYD - added 12/3/97)
41 = Ambulance - land
42 = Ambulance - air or water
50 = Federally qualified health centers
     (eff. 10/1/93)
51 = Inpatient psychiatric facility
52 = Psychiatric facility partial hospitalization
53 = Community mental health center
54 = Intermediate care facility/mentally
     retarded
55 = Residential substance abuse treatment
     facility
56 = Psychiatric residential treatment
     center
60 = Mass immunizations center (eff. 9/1/97)
```

```
                               61 = Comprehensive inpatient rehabilitation
                                    facility
                               62 = Comprehensive outpatient rehabilitation
                                    facility
                               65 = End stage renal disease treatment facility
                               71 = State or local public health clinic
                               72 = Rural health clinic
                               81 = Independent laboratory
1        LINE_PLC_SRVC_TB                        Line Place Of Service Table
         ----------------                        ---------------------------

                               99 = Other unlisted facility

1        LINE_PMT_IND_TB                         Line Payment Indicator Table
         ---------------                         ----------------------------


                               1 = Actual charge
                               2 = Customary charge
                               3 = Prevailing charge (adjusted, unadjusted
                                   gap fill, etc)
                               4 = Other (ASC fees, radiology and
                                   outpatient limits, and non-payment
                                   because of denial.
                               5 = Lab fee schedule
                               6 = Physician fee schedule - full fee
                                   schedule amount
                               7 = Physician fee schedule - transition
                               8 = Clinical psychologist fee schedule
                               9 = DME and prosthetics/orthotics fee
                                   schedules (eff. 4/97)

1        LINE_PRCSG_IND_TB                       Line Processing Indicator Table
         -----------------                       -------------------------------


                               A = Allowed
                               B = Benefits exhausted
                               C = Noncovered care
                               D = Denied (existed prior to 1991; from
                                   BMAD)
                               I = Invalid data
                               L = CLIA (eff 9/92)
                               M = Multiple submittal--duplicate line item
                               N = Medically unnecessary
                               O = Other
                               P = Physician ownership denial (eff 3/92)
                               Q = MSP cost avoided (contractor #88888) -
```

```
                                    voluntary agreement (eff. 1/98)
                               R = Reprocessed--adjustments based on
                                    subsequent reprocessing of claim
                               S = Secondary payer
                               T = MSP cost avoided - IEQ contractor
                                    (eff. 7/76)
                               U = MSP cost avoided - HMO rate cell
                                    adjustment (eff. 7/96)
                               V = MSP cost avoided - litigation
                                    settlement (eff. 7/96)
                               X = MSP cost avoided - generic
                               Y = MSP cost avoided - IRS/SSA data
                                    match project
                               Z = Bundled test, no payment
                                    (eff. 1/1/98)

    1   LINE_PRVDR_PRTCPTG_IND_TB                 Line Provider Participating Indicator Table
        -------------------------                 -------------------------------------------


                               1 = Participating
                               2 = All or some covered and allowed
                                    expenses applied to deductible Participating
                               3 = Assignment accepted/non-participating
                               4 = Assignment not accepted/non-participating
                               5 = Assignment accepted but all or some
                                    covered and allowed expenses applied
                                    to deductible Non-participating.
                               6 = Assignment not accepted and all covered
                                    and allowed expenses applied to deductible
                                    non-participating.
                               7 = Participating provider not accepting
                                    assignment.

    1       NCH_CLM_TYPE_TB                              NCH Claim Type Table
            ---------------                              --------------------


                              10 = HHA claim
                              20 = Non swing bed SNF claim
                              30 = Swing bed SNF claim
                              40 = Outpatient claim
                              41 = Outpatient 'Full-Encounter' claim
                                    (available in NMUD)
                              42 = Outpatient 'Abbreviated-Encounter' claim
                                    (available in NMUD)
                              50 = Hospice claim
                              60 = Inpatient claim
```

```
                        61 = Inpatient 'Full-Encounter' claim
                        62 = Inpatient 'Abbreviated-Encounter claim
                             (available in NMUD)
                        71 = RIC O local carrier non-DMEPOS claim
                        72 = RIC O local carrier DMEPOS claim
                        73 = Physician 'Full-Encounter' claim
                             (available in NMUD)
                        81 = RIC M DMERC non-DMEPOS claim
                        82 = RIC M DMERC DMEPOS claim
```

```
1          NCH_EDIT_TB                            NCH EDIT TABLE
           -----------                            --------------


                        A0X1 = (C) PHYSICIAN-SUPPLIER ZIP CODE
                        A000 = (C) REIMB > $100,000 OR UNITS > 150
                        A002 = (C) CLAIM IDENTIFIER (CAN)
                        A003 = (C) BENEFICIARY IDENTIFICATION (BIC)
                        A004 = (C) PATIENT SURNAME BLANK
                        A005 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
                        A006 = (C) DATE OF BIRTH IS NOT NUMERIC
                        A007 = (C) INVALID GENDER (0, 1, 2)
                        A008 = (C) INVALID QUERY-CODE (WAS CORRECTED)
                        A025 = (C) FOR OV 4, TOB MUST = 13,83,85,73
                        A1X1 = (C) PERCENT ALLOWED INDICATOR
                        A1X2 = (C) DT>97273,DG1=7611,DG<>103,163,1589
                        A1X3 = (C) DT>96365,DIAG=V725
                        A1X4 = (C) INVALID DIAGNOSTIC CODES
                        C050 = (U) HOSPICE - SPELL VALUE INVALID
                        D102 = (C) DME DATE OF BIRTH INVALID
                        D2X2 = (C) DME SCREEN SAVINGS INVALID
                        D2X3 = (C) DME SCREEN RESULT INVALID
                        D2X4 = (C) DME DECISION IND INVALID
                        D2X5 = (C) DME WAIVER OF PROV LIAB INVALID
                        D3X1 = (C) DME NATIONAL DRUG CODE INVALID
                        D4X1 = (C) DME BENE RESIDNC STATE CODE INVALID
                        D4X2 = (C) DME OUT OF DMERC SERVICE AREA
                        D4X3 = (C) DME STATE CODE INVALID
                        D5X1 = (C) TOS INVALID FOR DME HCPCS
                        D5X2 = (C) DME HCPCS NOC & NOC DESCRIP MISSING
                        D5X3 = (C) DME INVALID USE OF MS MODIFIER
                        D5X4 = (C) TOS9 NDC REQD WHEN HCPCS OMITTED
                        D5X5 = (C) TOS9 NDC REQD FOR Q0127-130 HCPCS
                        D5X6 = (C) TOS9 NDC/DIAGNOSIS CODE INVALID
                        D6X1 = (C) DME SUPPLIER NUMBER MISSING
                        D7X1 = (C) DME PURCHASE ALLOWABLE INVALID
                        D919 = (C) CAPPED/PEN PUMPS,NUM OF SRVCS > 1
                        D921 = (C) SHOE HCPC W/O MOD RT,LT REQ U=2/4/6
```

```
XXXX = (D) SYS DUPL: HOST/BATCH/QUERY-CODE
Y001 = (C) HCPCS R0075/UNITS>1/SERVICES=1
Y002 = (C) HCPCS R0075/UNITS=1/SERVICES>1
Y003 = (C) HCPCS R0075/UNITS=SERVICES
Y010 = (C) TOB=13X/14X AND T.C.>$7,500
Y011 = (C) INP CLAIM/REIM > $75,000
Z001 = (C) RVNU 820-859 REQ COND CODE 71-76
Z002 = (C) CC M2 PRESENT/REIMB > $150,000
Z003 = (C) CC M2 PRESENT/UNITS > 150
Z004 = (C) CC M2 PRESENT/UNITS & REIM < MAX
Z005 = (C) REIMB>99999 AND REIMB<150000
Z006 = (C) UNITS>99 AND UNITS<150
Z237 = (E) HOSPICE OVERLAP - DATE ZERO
0011 = (C) ACTION CODE INVALID
0013 = (C) CABG/PCOE AND INVALID ADMIT DATE
0014 = (C) DEMO NUM NOT=01-06,08,15,31
0015 = (C) ESRD PLAN BUT DEMO ID NOT = 15
0016 = (C) INVALID VA CLAIM
0017 = (C) DEMO=31,TOB<>11 OR SPEC<>08
0018 = (C) DEMO=31,ACT CD<>1/5 OR ENT CD<>1/5
0020 = (C) CANCEL ONLY CODE INVALID
0021 = (C) DEMO COUNT > 1
0301 = (C) INVALID HI CLAIM NUMBER
```

```
1        NCH_EDIT_TB                              NCH EDIT TABLE
         -----------                              --------------
```

```
0302 = (C) BENE IDEN CDE (BIC) INVAL OR BLK
04A1 = (C) PATIENT SURNAME BLANK (PHYS/SUP)
04B1 = (C) PATIENT 1ST INITIAL NOT-ALPHABETIC
0401 = (C) BILL TYPE/PROVIDER INVALID
0402 = (C) BILL TYPE/REV CODE/PROVR RANGE
0406 = (C) MAMMOGRAPHY WITH NO HCPCS 76092
0407 = (C) RESPITE CARE BILL TYPE 34X,NO REV 66
0408 = (C) REV CODE 403 /TYPE 71X/ PROV3800-974
0410 = (C) IMMUNO DRUG OCCR-36,NO REV-25 OR 636
0412 = (C) BILL TYPE XX5 HAS ACCOM. REV. CODES
0413 = (C) CABG/PCOE BUT TOB = HHA,OUT,HOS
0414 = (C) VALU CD 61,MSA AMOUNT MISSING
0415 = (C) HOME HEALTH INCORRECT ALPHA RIC
05X4 = (C) UPIN REQUIRED FOR TYPE-OF-SERVICE
05X5 = (C) UPIN REQUIRED FOR DME HCPCS
0501 = (C) UNIQUE PHY IDEN. (UPIN) BLANK
0502 = (C) UNIQUE PHY IDEN. (UPIN) INVALID
0601 = (C) GENDER INVALID
0701 = (C) CONTRACTOR INVALID CARRIER/ETC
0702 = (C) PROVIDER NUMBER INCONSISTANT
0703 = (C) MAMMOGRAPHY FOR NOT FEMALE
0704 = (C) INVALID CONT FOR CABG DEMO
```

```
                        0705 = (C) INVALID CONT FOR PCOE DEMO
                        0901 = (C) INVALID DISP CODE OF 02
                        0902 = (C) INVALID DISP CODE OF SPACES
                        0903 = (C) INVALID DISP CODE
                        1001 = (C) PROF REVIEW/ACT CODE/BILL TYPE
                        13X2 = (C) MULTIPLE ITEMS FOR SAME SERVICE
                        1301 = (C) LINE COUNT NOT NUMERIC OR > 13
                        1302 = (C) RECORD LENGTH INVALID
                        1401 = (C) INVALID MEDICARE STATUS CODE
                        1501 = (C) ADMIT DATE/ENTRY CODE INVALID
                        1502 = (C) ADMIT DATE > STAY FROM DATE
                        1503 = (C) ADMIT DATE INVALID WITH THRU DATE
                        1504 = (C) ADM/FROM/THRU DATE > TODAYS DATE
                        1505 = (C) HCPCS W SERVICE DATES > 09-30-94
                        1601 = (C) INVESTIGATION IND INVALID
                        1701 = (C) SPLIT IND INVALID
                        1801 = (C) PAY-DENY CODE INVALID
                        1802 = (C) HEADER AMT AND NOT DENIED CLAIM
                        1803 = (C) MSP COST AVD/ALL MSP LI NOT SAME
                        1901 = (C) AB CROSSOVER IND INVALID
                        2001 = (C) HOSPICE OVERRIDE INVALID
                        2101 = (C) HMO-OVERRIDE/PATIENT-STAT INVALID
                        2102 = (C) FROM/THRU DATE OR KRON/PAT STAT
                        2201 = (C) FROM/THRU DATE OR HCPCS YR INVAL
                        2202 = (C) STAY-FROM DATE > THRU-DATE
                        2203 = (C) THRU DATE INVALID
                        2204 = (C) FROM DATE BEFORE EFFECTIVE DATE
                        2205 = (C) DATE YEARS DIFFERENT ON OUTPAT
                        2207 = (C) MAMMOGRAPHY BEFORE 1991
                        2301 = (C) DOCUMENT CNTL OR UTIL DYS INVALID
                        2302 = (C) COVERED DAYS INVALID OR INCONSIST
                        2303 = (C) COST REPORT DAYS > ACCOMIDATION
                        2304 = (C) UTIL DAYS = ZERO ON PATIENT BILL
                        2305 = (C) UTIL DAYS = INCONSISTENCIES
                        2306 = (C) UTIL DYS/NOPAY/REIMB INCONSISTENT
                        2307 = (C) COND=40,UTL DYS >0/VAL CDE A1,08,09
1          NCH_EDIT_TB                              NCH EDIT TABLE
           -----------                              --------------

                        2308 = (C) NOPAY = R WHEN UTIL DAYS = ZERO
                        2401 = (C) NON-UTIL DAYS INVALID
                        2501 = (C) CLAIM RCV DT OR COINSURANCE INVAL
                        2502 = (C) COIN+LR>UTIL DAYS/RCPT DTE>CUR DTE
                        2503 = (C) COIN/TR TYP/UTIL DYS/RCPT DTE>PD/DEN
                        2504 = (C) COINSURANCE AMOUNT EXCESSIVE
                        2505 = (C) COINSURANCE RATE > ALLOWED AMOUNT
                        2506 = (C) COINSURANCE DAYS/AMOUNT INCONSIST
                        2507 = (C) COIN+LR DAYS > TOTAL DAYS FOR YR
```

```
2508 = (C) COINSURANCE DAYS INVALID FOR TRAN
2601 = (C) CLAIM PAID DT INVALID OR LIFE RES
2602 = (C) LR-DYS, NO VAL 08,10/PD/DEN>CUR+27
2603 = (C) LIFE RESERVE > RATE FOR CAL YEAR
2604 = (C) PPS BILL, NO DAY OUTLIER
2605 = (C) LIFE RESERVE RATE > DAILY RATE AVR.
28XA = (C) UTIL DAYS > FROM TO BENEF EXH
28XB = (C) BENEFITS EXH DATE > FROM DATE
28XC = (C) BENEFITS EXH DATE/INVALID TRANS TYPE
28XD = (C) OCCUR 23 WITH SPAN 70 ON INPAT HOSP
28XE = (C) MULTI BENE EXH DATE (OCCR A3,B3,C3)
28XF = (C) ACE DATE ON SNF (NOPAY =B, C, N, W)
28XG = (C) SPAN CD 70+4+6+9 NOT = NONUTIL DAYS
28XM = (C) OCC CD 42 DATE NOT = SRVCE THRU DTE
28XN = (C) INVALID OCC CODE
28X0 = (C) BENE EXH DATE OUTSIDE SERVICE DATES
28X1 = (C) OCCUR DATE INVALID
28X2 = (C) OCCUR = 20 AND TRANS = 4
28X3 = (C) OCCUR 20 DATE < ADMIT DATE
28X4 = (C) OCCUR 20 DATE > ADMIT + 12
28X5 = (C) OCCUR 20 AND ADMIT NOT = FROM
28X6 = (C) OCCUR 20 DATE < BENE EXH DATE
28X7 = (C) OCCUR 20 DATE+UTIL-COIN>COVERAGE
28X8 = (C) OCCUR 22 DATE < FROM OR > THRU
28X9 = (C) UTIL > FROM - THRU LESS NCOV
33X1 = (C) QUAL STAY DATES INVALID (SPAN=70)
33X2 = (C) QS FROM DATE NOT < THRU (SPAN=70)
33X3 = (C) QS DAYS/ADMISSION ARE INVALID
33X4 = (C) QS THRU DATE > ADMIT DATE (SPAN=70)
33X5 = (C) SPAN 70 INVALID FOR DATE OF SERVICE
33X6 = (C) TOB=18/21/28/51,COND=WO,HMO<>90091
33X7 = (C) TOB<>18/21/28/51,COND=WO
33X8 = (C) TOB=18/21/28/51,CO=WO,ADM DT<97001
33X9 = (C) TOB=32X SPAN 70 OR OCCR BO PRESENT
34X2 = (C) DEMO ID = 04 AND COND WO NOT SHOWN
3401 = (C) DEMO ID = 04 AND RIC NOT = 1
35X1 = (C) 60, 61, 66 & NON-PPS / 65 & PPS
35X2 = (C) COND = 60 OR 61 AND NO VALU 17
35X3 = (C) PRO APPROVAL COND C3,C7 REQ SPAN M0
36X1 = (C) SURG DATE < STAY FROM/ > STAY THRU
3701 = (C) ASSIGN CODE INVALID
3705 = (C) 1ST CHAR OF IDE# IS NOT ALPHA
3706 = (C) INVALID IDE NUMBER-NOT IN FILE
3710 = (C) NUM OF IDE# > REV 0624
3715 = (C) NUM OF IDE# < REV 0624
3720 = (C) IDE AND LINE ITEM NUMBER > 2
3801 = (C) AMT BENE PD INVALID
4001 = (C) BLOOD PINTS FURNISHED INVALID
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                                       4002 = (C) BLOOD FURNISHED/REPLACED INVALID
1   NCH_EDIT_TB   NCH EDIT TABLE
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                                       4003 = (C) BLOOD FURNISHED/VERIFIED/DEDUCT
                                       4201 = (C) BLOOD PINTS UNREPLACED INVALID
                                       4202 = (C) BLOOD PINTS UNREPLACED/BLOOD DED
                                       4203 = (C) INVALID CPO PROVIDER NUMBER
                                       4301 = (C) BLOOD DEDUCTABLE INVALID
                                       4302 = (C) BLOOD DEDUCT/FURNISHED PINTS
                                       4303 = (C) BLOOD DEDUCT > UNREPLACED BLOOD
                                       4304 = (C) BLOOD DEDUCT > 3 - REPLACED
                                       4501 = (C) PRIMARY DIAGNOSIS INVALID
                                       46XA = (C) MSP VET AND VET AT MEDICARE
                                       46XB = (C) MULTIPLE COIN VALU CODES (A2,B2,C2)
                                       46XC = (C) COIN VALUE (A2,B2,C2) ON INP/SNF
                                       46XG = (C) VALU CODE 20 INVALID
                                       46XN = (C) VALUE CODE 37,38,39 INVALID
                                       46XO = (C) VALUE CDE 38>0/VAL CDE 06 MISSNG
                                       46XP = (C) BLD UNREP VS REV CDS AND/OR UNITS
                                       46XQ = (C) VALUE CDE 37=39 AND 38 IS PRESENT
                                       46XR = (C) BLD FIELDS VS REV CDE 380,381,382
                                       46XS = (C) VALU CODE 39, AND 37 IS NOT PRESENT
                                       46XT = (C) CABG/PCOE,VC<>Y1,Y2,Y3,Y4,VA NOT>0
                                       46X1 = (C) VALUE AMOUNT INVALID
                                       46X2 = (C) VALU 06 AND BLD-DED-PTS IS ZERO
                                       46X3 = (C) VALU 06 AND TTL-CHGS=NC-CHGS(001)
                                       46X4 = (C) VALU (A1,B1,C1): AMT > DEDUCT
                                       46X5 = (C) DEDUCT VALUE (A1,B1,C1) ON SNF BILL
                                       46X6 = (C) VALU 17 AND NO COND CODE 60 OR 61
                                       46X7 = (C) OUTLIER(VAL 17) > REIMB + VAL6-16
                                       46X8 = (C) MULTI CASH DED VALU CODES (A1,B1,C1)
                                       46X9 = (C) DEMO ID=03,REQUIRED HCPCS NOT SHOWN
                                       4600 = (C) CAPITAL TOTAL NOT = CAP VALUES
                                       4601 = (C) CABG/PCOE, MSP CODE PRESENT
                                       4603 = (C) DEMO ID = 03 AND RIC NOT=6,7
                                       4901 = (C) PCOE/CABG,DEN CD NOT D
                                       4902 = (C) PCOE/CABG BUT DME
                                       50X1 = (C) RVCD=54,TOB<>13,23,32,33,34,83,85
                                       50X2 = (C) REV CD=054X,MOD NOT = QM,QN
                                       5051 = (E) EDB: NOMATCH ON 3 CHARACTERISTICS
                                       5052 = (E) EDB: NOMATCH ON MASTER-ID RECORD
                                       5053 = (E) EDB: NOMATCH ON CLAIM-NUMBER
                                       51XA = (C) HCPCS EYEWARE & REV CODE NOT 274
                                       51XC = (C) HCPCS REQUIRES DIAG CODE OF CANCER
                                       51XD = (C) HCPCS REQUIRES UNITS > ZERO
                                       51XE = (C) HCPCS REQUIRES REVENUE CODE 636
                                       51XF = (C) INV BILL TYP/ANTI-CAN DRUG HCPCS

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                       51XG = (C) HCPCS REQUIRES DIAG OF HEMOPHILL1A
                       51XH = (C) TOB 21X/P82=2/3/4;REV CD<9001,>9044
                       51XI = (C) TOB 21X/P82<>2/3/4:REV CD>8999<9045
                       51XJ = (C) TOB 21X/REV CD: SVC-FROM DT INVALID
                       51XK = (C) TOB 21X/P82=2/3/4,REV CD = NNX
                       51XL = (C) REV 0762/UNT>48,TOB NOT=12,13,85,83
                       51XM = (C) 21X,RC>9041/<9045,RC<>4/234
                       51XN = (C) 21X,RC>9032/<9042,RC<>4/234
                       51XP = (C) HHA RC DATE OF SRVC MISSING
                       51XQ = (C) NO RC 0636 OR DTE INVALID
                       51XR = (C) DEMO ID=01,RIC NOT=2
                       51XS = (C) DEMO ID=01,RUGS<>2,3,4 OR BILL<>21
                       51X0 = (C) REV CENTER CODE INVALID
                       51X1 = (C) REV CODE CHECK
1         NCH_EDIT_TB                                        NCH EDIT TABLE
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                       51X2 = (C) REV CODE INCOMPATIBLE BILL TYPE
                       51X3 = (C) UNITS MUST BE > 0
                       51X4 = (C) INP:CHGS/YR-RATE,ETC; OUTP:PSYCH>YR
                       51X5 = (C) REVENUE NON-COVERED > TOTAL CHRGE
                       51X6 = (C) REV TOTAL CHARGES EQUAL ZERO
                       51X7 = (C) REV CDE 403 WTH NO BILL 14 23 71 85
                       51X8 = (C) MAMMOGRAPHY SUBMISSION INVALID
                       51X9 = (C) HCPCS/REV CODE/BILL TYPE
                       5100 = (U) TRANSITION SPELL / SNF
                       5160 = (U) LATE CHG HSP BILL STAY DAYS > 0
                       5166 = (U) PROVIDER NE TO 1ST WORK PRVDR
                       5167 = (U) PROVIDER 1 NE 2: FROM DT < START DT
                       5169 = (U) PROVIDER NE TO WORK PROVIDER
                       5177 = (U) PROVIDER NE TO WORK PROVIDER
                       5178 = (U) HOSPICE BILL THRU < DOLBA
                       5181 = (U) HOSP BILL OCCR 27 DISCREPANCY
                       5200 = (E) ENTITLEMENT EFFECTIVE DATE
                       5201 = (U) HOSP DATE DIFFERENCE NE 60 OR 90
                       5202 = (E) ENTITLEMENT HOSPICE EFFECTIVE DATE
                       5202 = (U) HOSPICE TRAILER ERROR
                       5203 = (E) ENTITLEMENT HOSPICE PERIODS
                       5203 = (U) HOSPICE START DATE ERROR
                       5204 = (U) HOSPICE DATE DIFFERENCE NE 90
                       5205 = (U) HOSPICE DATE DISCREPANCY
                       5206 = (U) HOSPICE DATE DISCREPANCY
                       5207 = (U) HOSPICE THRU > TERM DATE 2ND
                       5208 = (U) HOSPICE PERIOD NUMBER BLANK
                       5209 = (U) HOSPICE DATE DISCREPANCY
                       5210 = (E) ENTITLEMENT FRM/TRU/END DATES
                       5211 = (E) ENTITLEMENT DATE DEATH/THRU
                       5212 = (E) ENTITLEMENT DATE DEATH/THRU
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                   5213 = (E) ENTITLEMENT DATE DEATH MBR
                   5220 = (E) ENTITLEMENT FROM/EFF DATES
                   5225 = (E) ENT INP PPS SPAN 70 DATES
                   5232 = (E) ENTL HMO NO HMO OVERRIDE CDE
                   5233 = (E) ENTITLEMENT HMO PERIODS
                   5234 = (E) ENTITLEMENT HMO NUMBER NEEDED
                   5235 = (E) ENTITLEMENT HMO HOSP+NO CC07
                   5236 = (E) ENTITLEMENT HMO HOSP + CC07
                   5237 = (E) ENTITLEMENT HOSP OVERLAP
                   5238 = (U) HOSPICE CLAIM OVERLAP > 90
                   5239 = (U) HOSPICE CLAIM OVERLAP > 60
                   524Z = (E) HOSP OVERLAP NO OVD NO DEMO
                   5240 = (U) HOSPICE DAYS STAY+USED > 90
                   5241 = (U) HOSPICE DAYS STAY+USED > 60
                   5242 = (C) INVALID CARRIER FOR RRB
                   5243 = (C) HMO=90091,INVALID SERVICE DTE
                   5244 = (E) DEMO CABG/PCOE MISSING ENTL
                   5245 = (C) INVALID CARRIER FOR NON RRB
                   525Z = (E) HMO/HOSP 6/7 NO OVD NO DEMO
                   5250 = (U) HOSPICE DOEBA/DOLBA
                   5255 = (U) HOSPICE DAYS USED
                   5256 = (U) HOSPICE DAYS USED > 999
                   526Y = (E) HMO/HOSP DEMO 5/15 REIMB > 0
                   526Z = (E) HMO/HOSP DEMO 5/15 REIMB = 0
                   527Y = (E) HMO/HOSP DEMO OVD=1 REIMB > 0
                   527Z = (E) HMO/HOSP DEMO OVD=1 REIMB = 0
                   5299 = (U) HOSPICE PERIOD NUMBER ERROR
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1          NCH_EDIT_TB                                      NCH EDIT TABLE
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                   5320 = (U) BILL > DOEBA AND IND-1 = 2
                   5350 = (U) HOSPICE DOEBA/DOLBA SECONDARY
                   5355 = (U) HOSPICE DAYS USED SECONDARY
                   5378 = (C) SERVICE DATE < AGE 50
                   5399 = (U) HOSPICE PERIOD NUM MATCH
                   5410 = (U) INPAT DEDUCTABLE
                   5425 = (U) PART B DEDUCTABLE CHECK
                   5430 = (U) PART B DEDUCTABLE CHECK
                   5450 = (U) PART B COMPARE MED EXPENSE
                   5460 = (U) PART B COMPARE MED EXPENSE
                   5499 = (U) MED EXPENSE TRAILER MISSING
                   5500 = (U) FULL DAYS/SNF-HOSP FULL DAYS
                   5510 = (U) COIN DAYS/SNF COIN DAYS
                   5515 = (U) FULL DAYS/COIN DAYS
                   5516 = (U) SNF FULL DAYS/SNF COIN DAYS
                   5520 = (U) LIFE RESERVE DAYS
                   5530 = (U) UTIL DAYS/LIFE PSYCH DAYS
                   5540 = (U) HH VISITS NE AFT PT B TRLR
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5550 = (E) SNF LESS THAN PT A EFF DATE
5600 = (D) LOGICAL DUPE, COVERED
5601 = (D) LOGICAL DUPE, QRY-CDE, RIC 123
5602 = (D) LOGICAL DUPE, PANDE C, E OR I
5603 = (D) LOGICAL DUPE, COVERED
5605 = (D) POSS DUPE, OUTPAT REIMB
5606 = (D) POSS DUPE, HOME HEALTH COVERED U
5623 = (U) NON-PAY CODE IS P
57X1 = (C) PROVIDER SPECIALITY CODE INVALID
57X2 = (C) PHYS THERAPY/PROVIDER SPEC INVAL
57X3 = (C) PLACE/TYPE/SPECIALTY/REIMB IND
57X4 = (C) SPECIALTY CODE VS. HCPCS INVALID
5700 = (U) LINKED TO THREE SPELLS
5701 = (C) DEMO ID=02,RIC NOT = 5
5702 = (C) DEMO ID=02,INVALID PROVIDER NUM
58X1 = (C) PROVIDER TYPE INVALID
58X9 = (C) TYPE OF SERVICE INVALID
5802 = (C) REIMB > $150,000
5803 = (C) UNITS/VISITS > 150
5804 = (C) UNITS/VISITS > 99
59XA = (C) PROST ORTH HCPCS/FROM DATE
59XB = (C) HCPCS/FROM DATE/TYPE P OR I
59XC = (C) HCPCS Q0036,37,42,43,46/FROM DATE
59XD = (C) HCPCS Q0038-41/FROM DATE/TYPE
59XE = (C) HCPCS/MAMMOGRAPHY-RISK/ DIAGNOSIS
59XG = (C) CAPPED/FREQ-MAINT/PROST HCPCS
59XH = (C) HCPCS E0620/TYPE/DATE
59XI = (C) HCPCS E0627-9/ DATE < 1991
59XL = (C) HCPCS 00104 - TOS/POS
59X1 = (C) INVALID HCPCS/TOS COMBINATION
59X2 = (C) ASC IND/TYPE OF SERVICE INVALID
59X3 = (C) TOS INVALID TO MODIFIER
59X4 = (C) KIDNEY DONOR/TYPE/PLACE/REIMB
59X5 = (C) MAMMOGRAPHY FOR MALE
59X6 = (C) DRUG AND NON DRUG BILL LINE ITEMS
59X7 = (C) CAPPED-HCPCS/FROM DATE
59X8 = (C) FREQUENTLY MAINTAINED HCPCS
59X9 = (C) HCPCS E1220/FROM DATE/TYPE IS R
5901 = (U) ERROR CODE OF Q
60X1 = (C) ASSIGN IND INVALID
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1       NCH_EDIT_TB                                    NCH EDIT TABLE
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                      6000 = (U) ADJUSTMENT BILL SPELL DATA
                      6020 = (U) CURRENT SPELL DOEBA < 1990
                      6030 = (U) ADJUSTMENT BILL SPELL DATA
                      6035 = (U) ADJUSTMENT BILL THRU DTE/DOLBA
                      61X1 = (C) PAY PROCESS IND INVALID
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61X2 = (C) DENIED CLAIM/NO DENIED LINE
61X3 = (C) PAY PROCESS IND/ALLOWED CHARGES
61X4 = (C) RATE MISSING OR NON-NUMERIC
6100 = (C) REV 0001 NOT PRESENT ON CLAIM
6101 = (C) REV COMPUTED CHARGES NOT=TOTAL
6102 = (C) REV COMPUTED NON-COVERED/NON-COV
6103 = (C) REV TOTAL CHARGES < PRIMARY PAYER
62XA = (C) PSYC OT PT/REIM/TYPE
62X1 = (C) DME/DATE/100% OR INVAL REIMB IND
62X6 = (C) RAD PATH/PLACE/TYPE/DATE/DED
62X8 = (C) KIDNEY DONO/TYPE/100%
62X9 = (C) PNEUM VACCINE/TYPE/100%
6201 = (C) TOTAL DEDUCT > CHARGES/NON-COV
6203 = (U) HOSPICE ADJUSTMENT PERIOD/DATE
6204 = (U) HOSPICE ADJUSTMENT THRU>DOLBA
6260 = (U) HOSPICE ADJUSTMENT STAY DAYS
6261 = (U) HOSPICE ADJUSTMENT DAYS USED
6265 = (U) HOSPICE ADJUSTMENT DAYS USED
6269 = (U) HOSPICE ADJUSTMENT PERIOD# (MAIN)
63X1 = (C) DEDUCT IND INVALID
63X2 = (C) DED/HCFA COINS IN PCOE/CABG
6365 = (U) HOSPICE ADJUSTMENT SECONDARY DAYS
6369 = (U) HOSPICE ADJUSTMENT PERIOD# (SECOND)
64X1 = (C) PROVIDER IND INVALID
6430 = (U) PART B DEDUCTABLE CHECK
65X1 = (C) PAYSCREEN IND INVALID
66?? = (D) POSS DUPE, CR/DB, DOC-ID
66XX = (D) POSS DUPE, CR/DB, DOC-ID
66X1 = (C) UNITS AMOUNT INVALID
66X2 = (C) UNITS IND > 0; AMT NOT VALID
66X3 = (C) UNITS IND = 0; AMT > 0
66X4 = (C) MT INDICATOR/AMOUNT
6600 = (U) ADJUSTMENT BILL FULL DAYS
6610 = (U) ADJUSTMENT BILL COIN DAYS
6620 = (U) ADJUSTMENT BILL LIFE RESERVE
6630 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
67X1 = (C) UNITS INDICATOR INVALID
67X2 = (C) CHG ALLOWED > 0; UNITS IND = 0
67X3 = (C) TOS/HCPCS=ANEST, MTU IND NOT = 2
67X4 = (C) HCPCS = AMBULANCE, MTU IND NOT = 1
67X6 = (C) INVALID PROC FOR MT IND 2, ANEST
67X7 = (C) INVALID UNITS IND WITH TOS OF BLOOD
67X8 = (C) INVALID PROC FOR MT IND 4, OXYGEN
6700 = (U) ADJUSTMENT BILL FULL/SNF DAYS
6710 = (U) ADJUSTMENT BILL COIN/SNF DAYS
68X1 = (C) INVALID HCPCS CODE
68X2 = (C) MAMMOGRAPY/DATE/PROC NOT 76092
68X3 = (C) TYPE OF SERVICE = G /PROC CODE
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                                    68X4 = (C) HCPCS NOT VALID FOR SERVICE DATE
                                    68X5 = (C) MODIFIER NOT VALID FOR HCPCS, ETC
                                    68X6 = (C) TYPE SERVICE INVALID FOR HCPCS, ETC
                                    68X7 = (C) ZX MOD REQ FOR THER SHOES/INS/MOD.
                                    68X8 = (C) LINE ITEM INCORRECT OR DATE INVAL.
1          NCH_EDIT_TB                                     NCH EDIT TABLE
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                                    69XA = (C) MODIFIER NOT VALID FOR HCPCS/GLOBAL
                                    69X3 = (C) PROC CODE MOD = LL / TYPE = R
                                    69X6 = (C) PROC CODE MOD/NOT CAPPED
                                    69X8 = (C) SPEC CODE NURSE PRACT, MOD INVAL
                                    6901 = (C) KRON IND AND UTIL DYS EQUALS ZERO
                                    6902 = (C) KRON IND AND NO-PAY CODE B OR N
                                    6903 = (C) KRON IND AND INPATIENT DEDUCT = 0
                                    6904 = (C) KRON IND AND TRANS CODE IS 4
                                    6910 = (C) REV CODES ON HOME HEALTH
                                    6911 = (C) REV CODE 274 ON OUTPAT AND HH ONLY
                                    6912 = (C) REV CODE INVAL FOR PROSTH AND ORTHO
                                    6913 = (C) REV CODE INVAL FOR OXYGEN
                                    6914 = (C) REV CODE INVAL FOR DME
                                    6915 = (C) PURCHASE OF RENT DME INVAL ON DATES
                                    6916 = (C) PURCHASE OF RENT DME INVAL ON DATES
                                    6917 = (C) PURCHASE OF LIFT CHAIR INVAL > 91000
                                    6918 = (C) HCPCS INVALID ON DATE RANGES
                                    6919 = (C) DME OXYGEN ON HH INVAL BEFORE 7/1/89
                                    6920 = (C) HCPCS INVAL ON REV 270/BILL 32-33
                                    6921 = (C) HCPCS ON REV CODE 272 BILL TYPE 83X
                                    6922 = (C) HCPCS ON BILL TYPE 83X -NOT REV 274
                                    6923 = (C) RENTAL OF DME CUSTOMIZE AND REV 291
                                    6924 = (C) INVAL MODIFIER FOR CAPPED RENTAL
                                    6925 = (C) HCPCS ALLOWED ON BILL TYPES 32X-34X
                                    6929 = (U) ADJUSTMENT BILL LIFE RESERVE
                                    6930 = (U) ADJUSTMENT BILL LIFE PSYCH DYS
                                    7000 = (U) INVALID DOEBA/DOLBA
                                    7002 = (U) LESS THAN 60/61 BETWEEN SPELLS
                                    7010 = (E) TOB 85X/ELECTN PRD: COND CD 07 REQD
                                    71X1 = (C) SUBMITTED CHARGES INVALID
                                    71X2 = (C) MAMMOGRPY/PROC CODE MOD TC,26/CHG
                                    72X1 = (C) ALLOWED CHGS INVALID
                                    72X2 = (C) ALLOWED/SUBMITTED CHARGES/TYPE
                                    72X3 = (C) DENIED LINE/ALLOWED CHARGES
                                    73X1 = (C) SS NUMBER INVALID
                                    73X2 = (C) CARRIER ASSIGNED PROV NUM MISSING
                                    74X1 = (C) LOCALITY CODE INVAL FOR CONTRACT
                                    76X1 = (C) PL OF SER INVAL ON MAMMOGRAPHY BILL
                                    77X1 = (C) PLACE OF SERVICE INVALID
                                    77X2 = (C) PHYS THERAPY/PLACE
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                       77X3 = (C) PHYS THERAPY/SPECIALTY/TYPE
                       77X4 = (C) ASC/TYPE/PLACE/REIMB IND/DED IND
                       77X6 = (C) TOS=F, PL OF SER NOT = 24
                       7701 = (C) INCORRECT MODIFIER
                       7777 = (D) POSS DUPE, PART B DOC-ID
                       78XA = (C) MAMMOGRAPHY BEFORE 1991
                       78X1 = (C) THRU DATE INVALID
                       78X3 = (C) FROM DATE GREATER THAN THRU DATE
                       78X4 = (C) FROM DATE > RCVD DATE/PAY-DENY
                       78X5 = (C) FROM DATE > PAID DATE/TYPE/100%
                       78X7 = (C) LAB EDIT/TYPE/100%/FROM DATE
                       79X3 = (C) THRU DATE>RECD DATE/NOT DENIED
                       79X4 = (C) THRU DATE>PAID DATE/NOT DENIED
                       8000 = (U) MAIN & 2NDARY DOEBA < 01/01/90
                       8028 = (E) NO ENTITLEMENT
                       8029 = (U) HH BEFORE PERIOD NOT PRESENT
                       8030 = (U) HH BILL VISITS > PT A REMAINING
                       8031 = (U) HH PT A REMAINING > 0
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1          NCH_EDIT_TB                                    NCH EDIT TABLE
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                       8032 = (U) HH DOLBA+59 NOT GT FROM-DATE
                       8050 = (U) HH QUALIFYING INDICATOR = 1
                       8051 = (U) HH # VISITS NE AFT PT B APPLIED
                       8052 = (U) HH # VISITS NE AFT TRAILER
                       8053 = (U) HH BENEFIT PERIOD NOT PRESENT
                       8054 = (U) HH DOEBA/DOLBA NOT > 0
                       8060 = (U) HH QUALIFYING INDICATOR NE 1
                       8061 = (U) HH DATE NE DOLBA IN AFT TRLR
                       8062 = (U) HH NE PT-A VISITS REMAINING
                       81X1 = (C) NUM OF SERVICES INVALID
                       83X1 = (C) DIAGNOSIS INVALID
                       8301 = (C) HCPCS/GENDER DIAGNOSIS
                       8302 = (C) HCPCS G0101 V-CODE/SEX CODE
                       8304 = (C) BILL TYPE INVALID FOR G0123/4
                       84X1 = (C) PAP SMEAR/DIAGNOSIS/GENDER/PROC
                       84X2 = (C) INVALID DME START DATE
                       84X3 = (C) INVALID DME START DATE W/HCPCS
                       84X4 = (C) HCPCS G0101 V-CODE/SEX CODE
                       84X5 = (C) HCPCS CODE WITH INV DIAG CODE
                       86X8 = (C) CLIA REQUIRES NON-WAIVER HCPCS
                       88XX = (D) POSS DUPE, DOC-ID,UNITS,ENT,ALWD
                       9000 = (U) DOEBA/DOLBA CALC
                       9005 = (U) FULL/COINS HOSP DAYS CALC
                       9010 = (U) FULL/COINS SNF DAYS CALC
                       9015 = (U) LIFE RESERVE DAYS CALC
                       9020 = (U) LIFE PSYCH DAYS CALC
                       9030 = (U) INPAT DEDUCTABLE CALC
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                              9040 = (U) DATA INDICATOR 1 SET
                              9050 = (U) DATA INDICATOR 2 SET
                              91X1 = (C) PATIENT REIMB/PAY-DENY CODE
                              92X1 = (C) PATIENT REIMB INVALID
                              92X2 = (C) PROVIDER REIMB INVALID
                              92X3 = (C) LINE DENIED/PATIENT-PROV REIMB
                              92X4 = (C) MSP CODE/AMT/DATE/ALLOWED CHARGES
                              92X5 = (C) CHARGES/REIMB AMT NOT CONSISTANT
                              92X7 = (C) REIMB/PAY-DENY INCONSISTANT
                              9201 = (C) UPIN REF NAME OR INITIAL MISSING
                              9202 = (C) UPIN REF FIRST 3 CHAR INVALID
                              9203 = (C) UPIN REF LAST 3 CHAR NOT NUMERIC
                              93X1 = (C) CASH DEDUCTABLE INVALID
                              93X2 = (C) DEDUCT INDICATOR/CASH DEDUCTIBLE
                              93X3 = (C) DENIED LINE/CASH DEDUCTIBLE
                              93X4 = (C) FROM DATE/CASH DEDUCTIBLE
                              93X5 = (C) TYPE/CASH DEDUCTIBLE/ALLOWED CHGS
                              9300 = (C) UPIN OTHER, NOT PRESENT
                              9301 = (C) UPIN NME MIS/DED TOT LI>0 FR DEN CLM
                              9302 = (C) UPIN OPERATING, FIRST 3 NOT NUMERIC
                              9303 = (C) UPIN L 3 CH NT NUM/DED TOT LI>YR DED
                              94A1 = (C) NON-COVERED FROM DATE INVALID
                              94A2 = (C) NON-COVERED FROM > THRU DATE
                              94A3 = (C) NON-COVERED THRU DATE INVALID
                              94A4 = (C) NON-COVERED THRU DATE > ADMIT
                              94A5 = (C) NON-COVERED THRU DATE/ADMIT DATE
                              94C1 = (C) PR-PSYCH DAYS INVALID
                              94C3 = (C) PR-PSYCH DAYS > PROVIDER LIMIT
                              94F1 = (C) REIMBURSEMENT AMOUNT INVALID
                              94F2 = (C) REIMBURSE AMT NOT 0 FOR HMO PAID
                              94G1 = (C) NO-PAY CODE INVALID
1       NCH_EDIT_TB                                    NCH EDIT TABLE
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                              94G2 = (C) NO-PAY CODE SPACE/NON-COVERD=TOTL
                              94G3 = (C) NO-PAY/PROVIDER INCONSISTANT
                              94G4 = (C) NO PAY CODE = R & REIMB PRESENT
                              94X1 = (C) BLOOD LIMIT INVALID
                              94X2 = (C) TYPE/BLOOD DEDUCTIBLE
                              94X3 = (C) TYPE/DATE/LIMIT AMOUNT
                              94X4 = (C) BLOOD DED/TYPE/NUMBER OF SERVICES
                              94X5 = (C) BLOOD/MSP CODE/COMPUTED LINE MAX
                              9401 = (C) BLOOD DEDUCTIBLE AMT > 3
                              9402 = (C) BLOOD FURNISHED > DEDUCTIBLE
                              9403 = (C) DATE OF BIRTH MISSING ON PRO-PAY
                              9404 = (C) INVALID GENDER CODE ON PRO-PAY
                              9407 = (C) INVALID DRG NUMBER
                              9408 = (C) INVALID DRG NUMBER (GLOBAL)
```

```
9409 = (C) HCFA DRG<>DRG ON BILL
9410 = (C) CABG/PCOE,INVALID DRG
95X1 = (C) MSP CODE G/DATE BEFORE 1/1/87
95X2 = (C) MSP AMOUNT APPLIED INVALID
95X3 = (C) MSP AMOUNT APPLIED > SUB CHARGES
95X4 = (C) MSP PRIMARY PAY/AMOUNT/CODE/DATE
95X5 = (C) MSP CODE = G/DATE BEFORE 1987
95X6 = (C) MSP CODE = X AND NOT AVOIDED
95X7 = (C) MSP CODE VALID, CABG/PCOE
96X1 = (C) OTHER AMOUNTS INVALID
96X2 = (C) OTHER AMOUNTS > PAT-PROV REIMB
97X1 = (C) OTHER AMOUNTS INDICATOR INVALID
97X2 = (C) GRUDMAN SW/GRUDMAN AMT NOT > 0
98X1 = (C) COINSURANCE INVALID
98X3 = (C) MSP CODE/TYPE/COIN AMT/ALLOW/CSH
98X4 = (C) DATE/MSP/TYPE/CASH DED/ALLOW/COI
98X5 = (C) DATE/ALLOW/CASH DED/REIMB/MSP/TYP
99XX = (D) POSS DUPE, PART B DOC-ID
9901 = (C) REV CODE INVALID OR TRAILER CNT=0
9902 = (C) ACCOMMODATION DAYS/FROM/THRU DATE
9903 = (C) NO CLINIC VISITS FOR RHC
9904 = (C) INCOMPATIBLE DATES/CLAIM TYPE
991X = (C) NO DATE OF SERVICE
9910 = (C) EDIT 9910 (NEW)
9911 = (C) BLOOD VERIFIED INVALID
9920 = (C) EDIT 9920 (NEW)
9930 = (C) EDIT 9930 (NEW)
9931 = (C) OUTPAT COINSURANCE VALUES
9933 = (C) RATE EXCEDES MAMMOGRAPHY LIMIT
9940 = (C) EDIT 9940 (NEW)
9942 = (C) EDIT 9942 (NEW)
9944 = (C) STAY FROM>97273,DIAG<>V103,163,7612
9945 = (C) SERVICE DATE < 98001
9946 = (C) INVALID DIAGNOSIS CODE
9947 = (C) INVALID DIAGNOSIS CODE
9948 = (C) STAY FROM>96365,DIAG=V725
9960 = (C) MED CHOICE BUT HMO DATA MISSING
9965 = (C) HMO PRESENT BUT MED CHOICE MISSING
9968 = (C) MED CHOICE NOT= HMO PLAN NUMBER
```

```
1    NCH_NEAR_LINE_RIC_TB                    NCH Near-Line Record Identification Code Table
     --------------------                    ---------------------------------------------


                        O = Part B physician/supplier claim
                            record (processed by local carriers;
                            can include DMEPOS services)
                        V = Part A institutional claim record
```

```
                         (inpatient (IP), skilled nursing
                         facility (SNF), christian science
                         (CS), home health agency (HHA), or
                         hospice)
                    W = Part B institutional claim record
                         (outpatient (OP), HHA)
                    U = Both Part A and B institutional home
                         health agency (HHA) claim records --
                         due to HHPPS and HHA A/B split.
                         (effective 10/00)
                    M = Part B DMEPOS claim record (processed
                         by DME Regional Carrier) (effective 10/93)
```

```
1         NCH_PATCH_TB                                NCH Patch Table
          ------------                                ---------------


                    01 = RRB Category Equatable BIC - changed (all
                         claim types) -- applied during the Nearline
                         'G' conversion to claims with NCH weekly
                         process date before 3/91.   Prior to Version
                         'H', patch indicator stored in redefined Claim
                         Edit Group, 3rd occurrence, position 2.
                    02 = Claim Transaction Code made consistent with
                         NCH payment/edit RIC code (OP and HHA) --
                         effective 3/94, CWFMQA began patch.  During
                         'H' conversion, patch applied to claims with
                         NCH weekly process date prior to 3/94.  Prior
                         to version 'H', patch indicator stored in
                         redefined Claim Edit Group, 4th occurrence,
                         position 1.
                    03 = Garbage/nonnumeric Claim Total Charge Amount
                         set to zeroes (Instnl) --  during the Version
                         'G' conversion, error occurred in the deriva-
                         tion of this field where the claim was missing
                         revenue center code = '0001'.   In 1994, patch
                         was applied to the OP and HHA SAFs only. (This
                         SAF patch indicator was stored in the redefined
                         Claim Edit Group, 4th occurrence, position 2).
                         During the 'H' ocnversion, patch applied to
                         Nearline claims where garbage or nonnumeric
                         values.
                    04 = Incorrect bene residence SSA standard county
                         code '999' changed (all claim types) --
                         applied during the Nearline 'G' conversion and
                         ongoing through 4/21/94, calling EQSTZIP
                         routine to claims with NCH weekly process
                         date prior to 4/22/94.  Prior to Version 'H'
```

                        patch indicator stored in redefined Claim
                        Edit Group, 3rd occurrence, position 4.
                   05 = Wrong century bene birth date corrected (all
                        claim types) -- applied during Nearline 'H'
                        conversion to all history where century
                        greater than 1700 and less than 1850; if
                        century less than 1700, zeroes moved.
                   06 = Inconsistent CWF bene medicare status code
                        made consistent with age (all claim types) --
                        applied during Nearline 'H' conversion to all
                        history and patched ongoing. Bene age is
                        calculated to determine the correct value;
                        if greater than 64, 1st position MSC ='1';
                        if less than 65, 1st position MSC = '2'.
                   07 = Missing CWF bene mediare status code derived
                        (all claim types) -- applied during Nearline
                        'H' conversion to all history and patched
                        ongoing, except claims with unknown DOB and/
                        or Claim From Date='0' (left blank).   Bene
                        age is calculated to determine missing value;
                        if greater than 64, MSC='10'; if less than
                        65, MSC = '20'.
                   08 = Invalid NCH primary payer code set to blanks
                        (Instnl) -- applied during Version 'H' con-
                        version to claims with NCH weekly process
                        date 10/1/93-10/30/95, where MSP values =

1   NCH_PATCH_TB   NCH Patch Table
         ------------   ---------------

                        invalid '0', '1', '2', '3' or '4' (caused
                        by erroneous logic in HCFA program code,
                        which was corrected on 11/1/95).
                   09 = Zero CWF claim accretion date replaced with
                        NCH weekly process date (all claim types)
                        -- applied during Version 'H' conversion to
                        Instnl and DMERC claims; applied during
                        Version 'G' conversion to non-institutional
                        (non-DMERC) claims. Prior to Version 'H',
                        patch indicator stored in redefined claim
                        edit group, 3rd occurrence, position 1.
                   10 = Multiple Revenue Center 0001 (Outpatient,
                        HHA and Hospice) -- patch applied to 1998 &
                        1999 Nearline and SAFs to delete any revenue
                        codes that followed the first '0001' revenue
                        center code.   The edit was applied across all
                        institutional claim types, including Inpatient/
                        SNF (the problem was only found with OP/HHA/
                        Hospice claims). The problem was corrected

6/25/99.
11 = Truncated claim total charge amount in the
       fixed portion replaced with the total charge
       amount in the revenue center 0001 amount field
       -- service years 1998 & 1999 patched during
       quarterly merge. The 1998 & 1999 SAFs were
       corrected when finalized in 7/99. The patch
       was done for records with NCH Daily Process
       Date 1/4/99 - 5/14/99.
12 = Missing claim-level HHA Total Visit Count --
       service years 1998, 1999 & 2000 patch applied
       during Version 'I' conversion of both the
       Nearline and SAFs.   Problem occurs in those
       claims recovered during the missing claims
       effort.
13 = Inconsistent Claim MCO Paid Switch made consistent
       with criteria used to identify an inpatient
       encounter claim -- if MCO paid switch equal to blank
       or '0' and ALL conditions are met to indicate an
       inpatient encounter claim (bene enrolled in a risk
       MCO during the service period), change the switch to
       a '1'. The patch was applied during the Version 'I'
       conversion, for claims back to 7/1/97 service thru date.

1   NCH_STATE_SGMT_TB   NCH State Segment Table
      ------------------   -----------------------

                           01 = Alabama
                           02 = Alaska
                           03 = Arizona
                           04 = Arkansas
                           05 = California
                           06 = Colorado
                           07 = Connecticut
                           08 = Delaware
                           09 = District of Columbia
                           10 = Florida
                           11 = Georgia
                           12 = Hawaii
                           13 = Idaho
                           14 = Illinois
                           15 = Indiana
                           16 = Iowa
                           17 = Kansas
                           18 = Kentucky
                           19 = Louisiana
                           20 = Maine

```
21 = Maryland
22 = Massachusetts
23 = Michigan
24 = Minnesota
25 = Mississippi
26 = Missouri
27 = Montana
28 = Nebraska
29 = Nevada
30 = New Hampshire
31 = New Jersey
32 = New Mexico
33 = New York
34 = North Carolina
35 = North Dakota
36 = Ohio
37 = Oklahoma
38 = Oregon
39 = Pennsylvania
40 = Puerto Rico
41 = Rhode Island
42 = South Carolina
43 = South Dakota
44 = Tennesee
45 = Texas
46 = Utah
47 = Vermont
48 = Virgin Islands
49 = Virginia
50 = Washington
51 = West Virginia
52 = Wisconsin
53 = Wyoming
54 = Africa
55 = Asia
56 = Canada
57 = Central America & West Indies
```

1   NCH_STATE_SGMT_TB   NCH State Segment Table
        ------------------   -----------------------

```
58 = Europe
59 = Mexico
60 = Oceania
61 = Philippines
62 = South America
63 = US Possessions
97 = Saipan - MP
98 = Guam
```

99 = American Samoa